Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: November 19, 2024
Inspection Number: 2024-1344-0003
Inspection Type: Complaint Critical Incident
Licensee: Schlegel Villages Inc.
Long Term Care Home and City: The Village of Sandalwood Park, Brampton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 18, 22-25, 28-30, 2024.

The following intake(s) were inspected:

- Intake: #00123677, related to infection prevention and control.
- Intake: #00123864, related to infection prevention and control.
- Intake: #00127470, a complaint related to skin and wound prevention and management, continence care and prevention of abuse and neglect.

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Continence Care
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Skin and wound care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee has failed to ensure that when a resident exhibited altered skin integrity, the resident received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, specific to the identified area.

Rationale and Summary

A registered practical nurse (RPN) was informed of a new area of altered skin integrity on the resident. However, a review of the resident's clinical records reflect that the Skin and Wound Evaluation assessment was not completed until three days later to determine what care and interventions should have been provided.

A Skin and Wound Evaluation was completed by the Nurse Practitioner (NP) and the resident was diagnosed with a new area of altered skin integrity and a treatment plan was put in place.

The Director of Care (DOC) stated that registered staff should have observed the wound and documented what the wound looked like when they were initially informed of the new area of altered skin integrity. The DOC confirmed that this

documentation was absent from the clinical records. The DOC further stated that a delay in treatment of an area of altered skin integrity can lead to the wound getting worse.

When the resident exhibited altered skin integrity and did not receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection the resident was placed at risk for delayed wound care.

Sources:
The resident's clinical records, Interview with DOC.

WRITTEN NOTIFICATION: Skin and wound care
NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (d)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated; and

The licensee has failed to ensure that the resident was repositioned.

Rationale and Summary

A review of the resident's clinical records indicate that the resident was diagnosed with two areas of altered skin integrity.

The resident requires assistance for repositioning.

The resident's clinical records indicate that they were not repositioned on four

occasions.

The DOC acknowledged that the documentation stating that resident was repositioned was absent on these four occasions.

By not repositioning the resident there may have been increased risk to the resident.

Sources:
The resident's clinical records, interview with DOC.