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 East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: February 4, 2024	
Inspection Number: 2024-1636-0001	
Inspection Type: Complaint	
Licensee: Mon Sheong Foundation	
Long Term Care Home and City: Mon Sheong Stouffville Long-Term Care Centre, Stouffville	
Lead Inspector Miko Hawken (724)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 10, 11, 12, 15, 16, 2024

The following complaint was inspected:

- A complaint related to concerns for resident regarding skin and wound care.

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

Skin and Wound Prevention and Management

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) (i)
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 ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee failed to ensure a skin assessment was completed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment for a resident.

Summary and Rationale

The Ministry of Long Term Care (MLTC) received a complaint regarding the care of a resident's wound, acquired at the long term care home (LTCH).

The LTCH's policy, states that a head-to-toe skin assessment and skin related risk assessment should be performed for all residents when there is a change in a residents health status that affects skin integrity or leave of absence for more than 24 hours.

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The resident's medical records indicated they were admitted to the LTCH from home on a specified date with a stage one pressure ulcer. Weekly assessments were completed by members of the registered staff and the wound improved with interventions in place.

The resident was admitted to hospital for an unrelated concern. On return an assessment tool, identified a stage one ulceration. The clinically appropriate assessment instrument, was not completed specifically for the ulcer that day.

The resident's ulcer was assessed by the Assistant Director of Resident Care (ADORC) using an assessment tool that documented a stage two ulcer, seven days after the resident was readmitted back to the home from the hospital.

The ADORC and the Skin and Wound Care Lead, stated that upon return from hospital, any resident with any alterations in skin integrity, such as an ulcer, a comprehensive assessment is to be completed. using the assessment tool, and this was not completed for the resident. They further stated that this delayed the appropriate wound care interventions for the resident.

Failing to ensure that the resident received a clinically appropriate skin assessment by a registered nursing staff member, upon the return from the hospital, there was a risk for delayed interventions, treatments and wound healing.

Sources: Resident clinical records, Mon Sheong LTCH's Resident Care Manual: Skin and Wound Care Program, interviews with staff. [724]

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

The licensee failed to provide immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection for a resident.

Summary and Rationale

A complaint was received to the Ministry of Long Term Care with concerns that a resident received inadequate care and treatment for their ulcer, which contributed to their death.

The LTCH's policy, states that one of the purposes of the program is to initiate prompt, appropriate treatment based on a developed management protocol.

The resident's medical records, found that they were admitted to the LTC home with a stage one ulcer. On admission an assessment was completed and indicated that resident was at risk for pressure injuries. Interventions to healing and further prevention were made for resident.

The resident's ulcer, progressed to a stage two ulcer. The ADORC, who at the time

was the skin and wound care lead, implemented, an air foam mattress that redistributes pressure, along with frequent turning and repositioning by direct care staff, nine days after they were admitted. It was noted that the resident refused to be turned and repositioned frequently.

The resident was hospitalized, unrelated to the ulcer, but it is noted in a skin assessment, that the wound was healing well.

The resident returned to the home from hospital, and it was noted in a skin assessment they had a stage one ulcer. A physiotherapy note indicated that resident was observed with a decline in their condition.

Weekly Skin and Wound evaluation assessments for the resident's ulcer indicated it was a stage two which remained stable or improving with no pain noted.

A Skin and Wound evaluation assessment indicated that resident's stage two ulcer was deteriorating. A different air mattress was implemented for pressure relief and repositioning, 22 days from their return from hospital.

The Skin and Wound Care Lead confirmed that any of the care staff could implement the use of a different air mattress and considering the resident's physical decline and further skin breakdown, this mattress should have been implemented in a more timely manner. The Skin and Wound Care Lead also stated that this could have reduced the risk of further skin break down for the resident who was bedridden.

Failing to ensure that the resident received timely interventions for their pressure injury, increased the risk of further skin break down, and infection.

Sources: Resident’s clinical records, Mon Sheong LTCH's Resident Care Manual Skin and Wound Care Program, interview with Skin and Wound Care Lead. [724]