Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 2, 2015	2015_326569_0005	L-002045-15	Resident Quality Inspection

Licensee/Titulaire de permis

WILDWOOD CARE CENTRE INC.
100 Ann Street Box 2200 ST. MARYS ON N4X 1A1

Long-Term Care Home/Foyer de soins de longue durée

WILDWOOD CARE CENTRE INC.
100 ANN STREET P.O. BOX 2200 ST. MARYS ON N4X 1A1

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

DONNA TIERNEY (569), MELANIE NORTHEY (563), REBECCA DEWITTE (521)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 16, 17, 18, 19, 20, and 25, 2015

The following Critical Incident inspections were conducted concurrently during this inspection:
Log # 001500-15 / CI 2802-000001-15

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Environmental Services Manager (ESM), a Registered Dietitian, the Food Services Manager (FSM), the Life Enrichment Co-ordinator, 2 Registered Nurses (RN), 3 Registered Practical Nurses (RPN), 4 Personal Support Workers (PSW), Residents and Family members.

The inspector(s) also conducted a tour of all Resident and common areas and made observations of Residents, activities, and care. Relevant policies and procedures, as well as clinical records and plans of care for identified Residents were reviewed. Inspector(s) observed meal and snack service, medication administration and drug storage areas, Resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **7 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used steps were taken to prevent Resident entrapment, taking into consideration all potential zones of entrapment.

Record review revealed the home underwent a bed entrapment risk audit on June 29, 2014, where seventeen beds failed zone 4.

Interview with the Environmental Services Manager (ESM) on March 18, 2015 revealed no corrective action was taken to date to prevent Resident entrapment for the seventeen identified beds.

Interview with the Administrator confirmed it was the home's expectation that corrective steps should have been taken to prevent Resident entrapment in the seventeen identified beds. [s. 15. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained. 2007, c. 8, s. 31 (2).
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the restraining of a Resident by a physical device may be included in the Resident's plan of care only if a Physician, Registered Nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining, and restraining of the Resident has been consented to by the Resident or, if the Resident is incapable, a substitute decision-maker of the Resident with authority to give that consent.

Record review revealed a specific Resident was assessed for the use of a restraint. Review of the current care plan for the Resident revealed the use of the restraint was not included. Additionally the Resident's clinical record, both hard copy and electronic, did not include an order or approval for the restraint's use, consent, care plan interventions, or monitoring.

Interview with the Director of Care (DOC) on March 19, 2015 confirmed it is the home's expectation that all Residents using a restraint should have the appropriate documentation including order, consent, care plan interventions, and monitoring.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the restraining of a Resident by a physical device may be included in a Resident's plan of care only if a Physician, Registered Nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining, and restraining of the resident has been consented to by the resident or, if the Resident is incapable, a substitute decision-maker of the Resident with authority to give that consent, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked, when not in use.

On March 19, 2015 observations revealed:

a) During the medication pass at 0800 hours the Registered Nurse (RN) failed to lock the medication cart while they administered medications to two Residents in their rooms. The RN had their back to the door and out of sight of the medication cart which was in the hallway.

b) During the medication administration for another Resident the RN was at the head of the bed and was not able to see the cart. The medication cart was unlocked. These observations were verified by the RN.

The Director of Care confirmed it was the home's expectation that the medication cart should be secure and locked when not in use.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that steps are taken to ensure the security of the drug supply including that drugs are stored in an area or a medication cart that is secure and locked, when not in use, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to Residents in accordance with the directions for use specified by the prescriber.

Observations on March 19, 2015 revealed:

a) A Resident was to be administered their prescribed medications at the 0800 hours medication pass. The RN administered one medication at 1000 hours and remaining medications were held until 1200 hours.

b) The RN added sweetener to crushed medications to certain Residents prior to administering them.

Record review of the Residents revealed there was no order for the sweetener to be given with the crushed medications.

Interview with the RN revealed they added the sweetener with the crushed medications as an experiment, so that certain Residents would not spit the medications out. They also acknowledged that the medications for the one Resident were not given at the prescribed times.

Interview with the DOC confirmed it was the homes expectation that drugs were to be administered to Residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to Residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. Observations throughout the course of the RQI revealed:

On March 18, 2015 at 0915 hours Inspector 563 observed the RN licking their fingers after eating food from a plate on the medication cart during the administration of Resident medications outside of the dining room. No hand hygiene was observed.

On March 19, 2015 at 0800 hours during the medication pass Inspector 521 observed the RN had failed to wash their hands in between residents receiving their medications. The lack of hand washing was verified with the RN.

On March 19, 2015 in the dining room Inspector 521 observed a Personal Support Worker (PSW) handle a used and soiled cloth and fork and failed to complete hand hygiene before returning to the table to finish feeding another Resident their breakfast.

Interview with the DOC confirmed it was the home's expectation that hand washing was to be completed during the medication pass in between Residents receiving their medications. The DOC further acknowledged that hand washing during the medication pass and after handling soiled items was expected of staff as part of the implementation of the home's infection prevention and control program. [s. 229. (4)]

2. On March 16, 2015, observations in shared Resident bathrooms revealed:

a) One soiled pink plastic basin inside a blue basin on the floor under the sink.
b) One unlabeled kidney basin with a used and unlabeled toothbrush and an unlabeled hair brush.
c) One tube of used and unlabeled toothpaste.

Interview with a PSW revealed all Resident personal care items need to labeled and stored in the Resident's night stand at the side of the bed. They also confirmed that unlabeled and unsanitary items do not meet the home's expectations that all personal items must be labeled and all items must be in clean condition and not stored on the floor. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of Residents are fully respected and promoted: Every Resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On March 19, 2015 at the 0800 hours medication pass observations revealed the RN failed to lock the health terminal while administering medications to Residents.The RN verified the health terminal which was located in the hallway had not been locked when unattended during the medication pass.

An interview with the Director of Care confirmed the home's expectation was to have the Resident's personal health information protected in accordance with the Personal Health Information Protection Act. [s. 3. (1) 11. iv.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that their policy related to Personal Assistance Services Device (PASD) is complied with.

On March 19, 2015, a Resident was observed sitting in a reclined position in a PASD.

Record review of the home's policy "Least Restraint, Last Resort" Policy CS-5.1 stated: "All documentation for restraints/PASD will be kept in the section of the chart labeled restraints. The section will include the following: the consent, the assessment, the monitoring forms with the exception of the physician order which will be in the physician order section of the chart."

Record review of the Resident's clinical record revealed there was an order and assessment for the PASD but there was no documented evidence of consent.

Interview with the DOC confirmed a consent form was not present for the Resident's PASD and there should be as per the home's policy. [s. 8. (1) (b)]

Issued on this 2nd day of April, 2015

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.