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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Jan 16, 2017	2017_457630_0001	032083-16	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

AMIE GIBBS-WARD (630), NANCY SINCLAIR (537)

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): January 9, 10, 11, 12 and 13, 2017.

The following Critical Incident inspections were conducted within this Resident Quality Inspection (RQI):
Critical Incident Log #026103-16/CI 2802-000010-16 – related to falls prevention;
Critical Incident Log #015283-16/CI 2802-000004-16 – related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the RAI Co-ordinator, the Life Enrichment Co-oordinator, the Registered Dietitian (RD), three Registered Nurses (RN), one Registered Practical Nurses (RPN), eight Nurses Aides (NA), four family members and over twenty residents.

The inspectors also observed resident rooms and common areas, observed medication storage areas, observed medication administration, observed residents and the care provided
to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home and reviewed various meeting minutes.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care

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

4 WN(s)
4 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A) An identified resident was observed in a specific device that did not match the interventions listed in the plan of care or Kardex for this resident.

Interviews with multiple staff members of the home indicated that this identified resident no longer used the specific device that was listed in the plan of care.

Review of the assessments for this identified resident showed no documented assessment regarding use of the specific device listed in the plan of care.

During an interview with the Director of Care (DOC) it was reported this identified resident did not need the specific device listed in the plan of care. The DOC said that the plan of care did not reflect an assessment or the resident's current needs regarding the use of this device. [s. 6. (2)]

B) A review of the most recent assessment for an identified resident stated that the resident was occasionally incontinent, used a specific continence care product and

required a specific level of assistance with toileting.

Observation of the continence care products provided for this identified resident found they matched the care product specified in the assessment. Interview with this identified resident for use by this resident verified this was the product they preferred and used.

Interviews with multiple staff members of the home indicated that this identified resident preferred to use the continence care product specified in the assessment and this did not match the product that was listed in the plan of care. The staff members also reported that the plan of care did not reflect the level of assistance with toileting that the resident preferred.

The care plan for this identified resident listed a different continence care product and a different level of assistance with toileting than were listed in the assessment.

The Director of Care (DOC) stated during interview that a change in a continence product should have been completed using a specific form and the care plan should have been updated to reflect the most current assessment and needs of the resident for continence care. [s. 6. (2)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Review of the assessments completed on admission, 90 days post admission and 180 days post admission for an identified resident indicated this resident was continent.

Review of the care plan for this identified resident indicated that they were continent.

The most recent tasks for bowel function in Point of Care (POC) for this identified resident indicated the resident was incontinent on 17 out of 30 days (57% of the time).

During an interview with a staff member of the home it was reported that this identified resident was frequently incontinent and required regular toileting and checks by staff as the resident was unable to complete appropriate self-care as a result of incontinence.

During an interview with the Director of Care (DOC) it was reported that this identified resident was incontinent. The DOC said the assessments for continence and the care

plan for this identified resident were not consistent with each other and as a result the plan of care did not reflect the actual care needs of the resident. [s. 6. (4) (a)]

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 plan of care is based on an assessment of the resident and the needs and preferences of that resident and that the staff collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, 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 has failed to ensure that the restraining of a resident by a physical device was included in the plan of care only if the required conditions were satisfied.

Multiple observations during the inspection found an identified resident was using specific devices.

Multiple staff in the home reported that they used the specific devices for this resident and the use of these devices did potentially affect the resident's ability to get out of the chair.

Review of the clinical record for this identified resident found that there was no assessment completed for these devices, there was no documented monitoring of these devices, there was no restraint consent form completed for these devices, there was no Physician or Nurse Practitioner order for these devices and the plan of care for these devices was incomplete.

During an interview with the Director of Care (DOC) they acknowledged that this resident did not have the appropriate documentation for the use of the specific devices including an order, assessment, an updated plan of care, the appropriate consent form for restraints and monitoring. The DOC said it was the expectation in the home that these would be in place for residents being restrained by physical devices. [s. 31. (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 the restraining of a resident by a physical device is included in a resident's plan of care only if all of the following are satisfied: 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,a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining, 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, and the plan of care provides for everything required under subsection (3). 2007, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Review of the clinical record for an identified resident found that this resident experienced a fall which resulted in an injury. No Post Fall Investigation Assessment or other fall assessment forms or falls progress notes were observed in the clinical record for this resident regarding this fall.

Interviews with multiple staff in the home found that this identified resident did not have a documented post fall assessment completed for this specific fall.

During an interview with the Director of Care (DOC) it was acknowledged that a post fall assessment was not completed for this specific fall. The DOC said that it was the expectation in the home that a post fall assessment was completed using the Post Falls Investigation Assessment in Point Click Care (PCC) for all falls. [s. 49. (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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (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,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff.

Review of the assessments completed for an identified resident found that this resident was assessed to have a specific area of altered skin integrity.

During an interview with a staff member in the home it was reported that this identified resident did have a specific area of altered skin integrity. This staff member stated that there should have been a treatment regime initiated in the electronic Treatment Administration Record (eTAR) and that there should be documentation of assessment of the area at minimum weekly until resolved, and the assessment was to be completed using the Skin/Wound note in PCC. This staff member reviewed the clinical record of this identified resident and was not able to locate either an order for treatment on the eTAR or documentation of weekly assessment in the PCC notes.

Further review of the clinical record found no documented weekly assessment of the altered skin integrity.

The Director of Care (DOC) stated during interview that all areas of altered skin integrity should have a treatment initiated in the eTAR, and an assessment completed and documented as a Skin/Wound noted in PCC at a minimum weekly. DOC reviewed the clinical record for this resident and was not able to locate documented weekly assessments. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

Issued on this 16th day of January, 2017

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

Original report signed by the inspector.