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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 14, 2018	2018_729615_0049	022638-18, 025642-18, 029662-18	Complaint

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
100 Ann Street P.O. Box2200 ST. MARYS ON N4X 1A1

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

HELENE DESABRAIS (615)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 10, 11 and 12, 2018.

The following complaints were inspected:

Complaint IL-61470-LO/Log #029662-18 related to responsive behaviours;
Complaint IL-59257-LO/IL-59432-LO/Log #022638-18 related to safe and secure home;
Complaint IL-60129-LO/IL-60140-LO/IL-60144-LO/Log #025642-18 related to accommodation services - maintenance.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), two Registered Nurse (RNs), a Physiotherapist Assistant and two Personal Support Workers (PSWs).

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	Légende 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. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. 2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. 3. A response shall be made to the person who made the complaint, indicating, i. what the licensee has done to resolve the complaint, or ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

On a specific date, Complaint IL-61470-LO/Log # 029662-18 was submitted to the Ministry of Health and Long Term Care (MOHLTC) related to complainant being fearful of their safety.

During an interview, the complainant stated that a resident had threatened them and two weeks prior the resident had exposed themself to them. The complainant stated that they brought their concerns to the Administrator and the Director of Care (DOC).

A review of the home's policy #AM-6.1 "Complaints procedure" dated November 2010 stated in part “Every complaint made related to the care of a resident or the operation of the home shall be investigated in a timely, thorough and impartial manner. In the event the complaint alleges harm or potential harm to a resident, an investigation shall begin immediately”.

A review of the home's "Residents' Council Meeting Minutes" on a specific date, stated in part that a resident brought forth that they felt unsafe with a particular resident in the home.

A review of the home's "Response to Resident Council Meeting" signed by Administrator #100 on a specific date, stated in part "We ask if you see a resident that is touching stuff, entering your room uninvited or are concerned of them, to please find staff member to help redirect the resident and replace any items they have touched". A review of the home's complaints/concerns file for the complainant did not mention the concerns regarding them being fearful of their safety with the resident. Also there were no documented evidence that the home conducted an investigation to resolve the complainant’s concerns/complaint.

During an interview, a Personal Support Worker (PSW) stated that the resident had behaviours and was intimidating.

During an interview, another PSW stated that the resident was intimidating and was afraid of what the resident could do to them.

During an interview, a family member stated that the resident was “a hand full" and had behaviours.

During an interview, a Physiotherapist Assistant stated that the resident had behaviours and just knew to not be around them when they were in a bad mood.

During an interview, a Registered Nurse (RN) stated that they were personally "scared to death" of this resident as the resident once told them "I'm going to smash you in the face".

During an interview, the Administrator stated that the residents' council's minute on a specific date that stated one resident brought forth that they felt unsafe with a particular resident in the home was indeed the complainant and that this specific concern was not investigated. The Administrator said that the home's expectation would have been that the complainant's concerns/complaint would be immediately investigated and resolved. [s. 101. (1)]

Issued on this 14th day of December, 2018

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

Original report signed by the inspector.