Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux 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
Feb 4, 2020	2020_790730_0004	023678-19, 000621-20	Critical Incident System

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. Box 2200 ST. MARYS ON N4X 1A1

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

CHRISTINA LEGOUFFE (730)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 28 and 30, 2020

The following Critical Incident System (CIS) Intakes were included in this inspection:

Log #023678-19/ CI #2802-000018-19 related to falls prevention.
Log #000621-20/ CI #2802-000001-20 related to falls prevention.

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

The inspector also reviewed resident clinical records and plans of care, policies and procedures of the home, and observed residents and the care provided to them.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care set out clear directions to staff and others who provided care to a resident.

A) The Ministry of Long-Term Care (MOLTC) received a Critical Incident System (CIS) report, on a specified date, related to an incident with hospital transfer for resident #002.

A review of the plan of care in Point Click Care (PCC), for resident #002 included a focus and specified interventions related to transferring.

A review of the progress notes in PCC for resident #002, included two progress notes, which specified a specific transfer type that was assessed for resident #002.

During an interview, Personal Support Worker (PSW) #102 said they looked at the Kardex in PCC to find information related to a resident's care needs and also used the transfer logos in resident rooms to determine what their needs were for transferring. They said they were familiar with resident #002 and that they were currently using a specified mobility device. They said that resident #002 currently required a specific transfer type.

During an observation of resident #002's room, PSW #102 confirmed that the transfer logo in resident #002's room indicated that they were a specified transfer type.

During an interview, Director of Care (DOC) #100 said that staff used the Kardex that

they have access to in Point of Care (POC) to know what interventions were in place for a resident. They said that transfer status was assessed by registered staff or the Physiotherapist (PT). They said that transfer assessments, other than the assessment on admission, were documented in the progress notes. In regards to resident #002, DOC #100 said that a specified intervention should have been removed from their plan of care as they currently required a different type of transfer. They said that the care plan did not provide clear direction for staff in terms of transferring. [s. 6. (1) (c)]

2. During an interview with DOC #100, resident #003 was identified as a resident who had recently had an unwitnessed fall.

A review of the plan of care in Point Click Care (PCC), for resident #003 included a focus and specified interventions related to transferring.

Review of the assessments section in PCC included a specific assessment, which stated that resident #003 required a specific type of transfer.

During an observation of resident #003’s room by inspector #730 the transfer logo near the head of resident #003’s bed indicated that they required a specified type of transfer.

During an interview Director of Care (DOC) #100 said that resident #003’s care plan indicated that they required a specified type of transfer, but that the most recent specified assessment indicated that they required a different type of transfer. The DOC confirmed that the transfer logo in resident #003’s room indicated that they required a specific type of transfer, which was different than what was documented in the plan of care. They said that the plan of care did not provide clear direction for staff and that the transfer status should have been updated in the plan of care.

The licensee has failed to ensure that the plan of care provided clear direction related to the transferring needs of residents #002 and #003. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

The Ministry of Long-Term Care (MOLTC) received a Critical Incident System (CIS) report, on a specified date, related to an incident with hospital transfer for resident #002.

Review of the plan of care for resident #002 showed a focus related to falls prevention.

There were interventions specified related to this focus.

A review of the “Documentation Survey Report-v2” for a specified time frame, for resident #002, did not show the specified intervention, related to falls prevention, as one of the “interventions/tasks” documented.

During an interview, Personal Support Worker #102 said that the specified intervention, related to falls prevention, was documented on Point of Care (POC), but that they did not see it as a task on POC for resident #002.

During an interview, Director of Care (DOC) #100 said that the specified intervention was part of resident #002’s current plan of care related to falls prevention. They said that this intervention was added to their plan of care at a specified time. They said that staff had brought it to their attention the day before that this task was not on POC and they had added it the day before.

A second review of the “Documentation Survey Report v2” for a specified time frame, included the specified task related to falls prevention. [s. 6. (9) 1.]

4. During an interview with DOC #100, resident #003 was identified as a resident who had recently had an unwitnessed fall.

Review of the plan of care for resident #003 showed a focus related to falls prevention with specified interventions.

A review of the “Documentation Survey Report-v2” for resident #003, for a specified time frame, did not show the specified intervention, related to falls prevention, as one of the “interventions/tasks” documented.

During an interview, Director of Care (DOC) #100 said that the specified intervention was part of resident #003’s current plan of care related to falls prevention. They said that this task/intervention was not on POC and that they could not ensure that this intervention was in place because there was no documentation of the intervention.

The licensee has failed to ensure that a specified intervention, related to falls prevention, that was part of resident #002 and #003’s plans of care was documented. [s. 6. (9) 1.]

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 resident plans of care provide clear directions to staff and others who provide care to residents and that the care provided to residents is documented, to be implemented voluntarily.

WN #2: 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 where the Act or the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

In accordance with O. Reg 79/10, s. 48 (1) 1, and in reference to O. Reg 79/10 s. 49 (1) the licensee was required to have a falls prevention and management program that provided policies to monitor residents.

Specifically, staff did not comply with the licensee's "Resident Falls" policy (OTP-OPFP-8.6), which was part of the licensee's Falls Prevention and Falls Management program, which required registered staff to complete a Head Injury Routine (HIR) if there was any possibility of a head injury as a result of a fall.

The Ministry of Long-Term Care (MOLTC) received a Critical Incident System (CIS)

report on a specified date, related to an incident with hospital transfer for resident #001.

A review of the Resident Assessment Instrument Minimum Data Set (RAI-MDS), included a specified Cognitive Performance Scale (CPS) score for resident #001, which indicated that the resident had a specified level of cognitive impairment.

The clinical records for resident #001 were reviewed in PCC and showed an assessment titled “Post Fall Investigation Assessment V-2,” on a specified date. The assessment documented the fall as not observed. There was no response documented under the “Neurological Assessment” section of the assessment.

A further review of the assessments section in PCC did not show a HIR completed for resident #001 related to the fall on the specified date.

During an interview between inspector #730 and resident #001, resident #001 said that they could not recall having any falls while living in the home.

During an interview, Registered Nurse (RN) #104 said that Head Injury Routines (HIRs) were completed when a resident had an unwitnessed fall and were not able to say if they hit their head or not, or if it was witnessed and they hit their head. They said that if the resident was cognitively impaired, it would depend on the situation whether they would complete an HIR. RN #104 said that HIRs are completed on PCC under the assessments section. They said that resident #001 was cognitively impaired. They also said that resident #001’s fall was unwitnessed, that the resident had stated that they had not hit their head, and that a HIR was not completed related to the fall.

During an interview, Director of Care (DOC) #100 said that they were the Falls Program Lead for the home. They said that registered staff completed a HIR for an unwitnessed fall when staff were not sure if the resident had hit their head or if they knew the resident had hit their head. When asked where the policy says, “If any possibility of a head injury, check pupil reaction: initiate Head Injury Routine,” how would staff know if there was a possibility of a head injury, the DOC said that staff would use visual signs, resident statements, an assessment of the resident's head, or if was witnessed that they hit their head. When asked what the process in the home was if a resident who was cognitively impaired had an unwitnessed fall, but said that they did not hit their head, the DOC said that they would still have to do the assessment for the HIR if the resident was cognitively impaired. Regarding resident #001, the DOC said that they had some cognitive impairment. They said that regarding their fall on the specified date, there was no HIR

assessment and they expected an HIR would have been completed. They said that the resident stated that they did not hit their head, but that since the fall was unwitnessed one should have been completed. [s. 8. (1) (a),s. 8. (1) (b)]

2. The MOLTC received a CIS report on a specified date, related to a fall with hospital transfer for resident #002.

A review of the Resident Assessment Instrument Minimum Data Set (RAI-MDS), included a specified Cognitive Performance Scale (CPS) score for resident #002, which indicated that the resident had a specified level of cognitive impairment.

The clinical records for resident #002 were reviewed in PCC and showed an assessment titled “Post Fall Investigation Assessment V-2,” with a specified date. The assessment documented the fall as not observed. There was no response documented under the “Neurological Assessment” section of the assessment.

A further review of the assessments section in PCC did not show a HIR completed for resident #002 related to the fall on the specified date.

During an interview, Registered Nurse (RN) #104 said that they were working when resident #002 fell on the specified date. They said that the fall was unwitnessed and that the resident’s cognitive status prior to the fall was impaired. They said that no HIR was completed because the resident told them that they did not hit their head.

During an interview, Director of Care #100 said that resident #002 was cognitively impaired and that they had a specified CPS score. They said that the resident sustained a specified injury as a result of the fall and that the fall had been unwitnessed. They said that a HIR was not completed related to this fall, but expected that one would have been completed.

The licensee has failed to ensure that when residents #001 and #002 fell that a head injury routine was completed as per the home’s policy. [s. 8. (1) (a),s. 8. (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 the home's policy related to the completion of head injury routines is complied with, 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 fell, a post- fall assessment was completed.

The Ministry of Long-Term Care (MOLTC) received a Critical Incident System (CIS) report on a specified date, related to a fall with hospital transfer for resident #001.

The clinical records for resident #001 were reviewed in PCC and showed an assessment titled “Post Fall Investigation Assessment V-2,” on a specified date. Upon review of the post-falls assessment there were sections of the assessment that had not been completed. There was no response documented on the assessment related to neurological assessments, mechanical devices used, mental status, need for a transfer to hospital, or if the manager, physician, or family were notified.

During an interview, Registered Nurse (RN) #104 said that the “Post Fall Investigation Assessment” was completed in PCC, after a fall, by registered staff. RN #104 stated that the post-fall assessment for resident #001’s fall on a specified date had some gaps in the documentation and was not completed.

During an interview, Director of Care (DOC) #100 said that they were the Falls Program Lead for the home. They said that registered staff completed post falls assessments under the assessments tab on PCC when a resident fell. Upon review, they stated that there were sections of resident #001’s post-fall assessment that were not completed and that they would expect that those sections would have been completed.

The licensee has failed to ensure that when resident #001 fell, a post-falls assessment was completed. [s. 49. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident under subsection (1) (3) or (3.1), within 10 days of becoming aware of the incident, with the outcome or current status of the individual who was involved in the incident.

The Ministry of Long-Term Care (MOLTC) received a Critical Incident System (CIS) report on a specified date, related to a fall with hospital transfer for resident #002. The Central Intake Assessment and Triage Team (CIATT) requested that the home amend the report to include the status of the resident upon return to the facility, including dates, and injuries noted within the last six months on a specified date. Review of the amended CIS report did not include the resident's injuries or current status.

During an interview, Director of Care (DOC) #100 said that resident #002 had sustained a specified injury, and a significant change in status, as a result of their fall on the specified date. They said that the CIS report did not state that resident #002 had sustained a the specified injury and expected that the home would have updated the report to indicate the outcome of the incident.

The licensee failed to ensure that the Director was informed of an incident under subsection (1) (3) or (3.1), within 10 days of becoming aware of the incident, with the outcome of resident #002. [s. 107. (4) 3. v.]

Issued on this 4th day of February, 2020

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

Original report signed by the inspector.