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
Jun 7, 2021	2021_797740_0013	003625-21, 003860-21, 005759-21	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

SAMANTHA PERRY (740)

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): May 31, June 01, 02 and 03, 2021.

The following intakes were completed within this Follow Up and Critical Incident Systems inspection:
Log# 003860-21 for Compliance Order #001 from Inspection #2021_777731_0006 related to the home's falls policies;
Log# 003625-21 / CI# 2802-000003-21 related to falls management; and
Log# 005759-21 / CI# 2802-000004-21 also related to falls management.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Housekeepers and residents.

The inspector(s) also made various observations, including Infection Prevention and Control practices and reviewed residents' clinical records.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 8. (1)	CO #001	2021_777731_0006	740

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. 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 the home's policy related to falls management was complied with for resident #003.

In accordance with O. Reg. 79/10, s. 30, the licensee was required to have a written description of each of the interdisciplinary programs, including falls prevention and management, required under section 48 of this Regulation that included relevant policies provided for methods to reduce risk and monitor outcomes. Specifically, staff did not comply with the home's "Resident Falls" policy (effective May 2017), which was part of their falls prevention and management program.

During the course of this inspection the fall of resident #003 was reviewed, and the resident's clinical records documented an incomplete post fall assessment.

The home's "Resident Falls" policy requires registered staff to assess the resident before moving him or her. Then, when the nursing assessment indicates it is safe to move the resident, the resident should be returned to bed for a more thorough examination. This examination includes specific items and a review of resident #003's clinical records showed no documentation of these specific items as per the home's policy.

Registered Practical Nurse (RPN) #104 said, every resident who has fallen must be assessed by a registered staff member and the assessment must include specific items as per the home's policy.

Director of Care #101 reviewed resident #003's clinical records on PCC and said the assessment form was not filled out in full by the registered staff member and should have been.

Administrator #100 and DOC #101 both said, it was their expectation that the resident be assessed in full when they have fallen and the registered staff are expected to complete all required documentation on PCC before leaving the Long Term Care Home at the end of their shift. Resident #003's risk increased when the resident was not assessed in full post fall in accordance with the home's "Resident Falls" policy.

Sources: Resident #003's clinical records; the home's policy "Resident Falls", number OTP-OPFP-8.6 (effective May 2017); and interviews with the Administrator, DOC and other staff. [s. 8. (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 by ensuring that all staff are following the home's "Resident Falls" policy, to be implemented voluntarily.

WN #2: 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 resident #001 had fallen, they were assessed.

The Ministry of Long Term Care (MLTC) received a critical incident report documenting resident #001's fall.

The home's "Resident Falls" policy, effective May 2017 documented, the registered staff member shall be responsible to assess the resident's condition before moving him or her.

Resident #001's clinical records documented that the resident had a fall and further review showed no documentation of an assessment completed by registered staff when the resident had fallen, before the resident was moved.

PSW #103 witnessed resident #001's fall, assisted the resident and then called for help. PSW #108 arrived, as well as Registered Nurse (RN) #107. PSW #103 recounted the events of the residents fall to RN #107 and the RN said the PSW could continue with the resident's routine.

Registered Practical Nurse (RPN) #104 said every resident who has fallen must be assessed post fall by a registered staff member before moving them, to determine whether it is safe to move the resident or not.

RN #107 said they didn't assess the resident before moving them because they didn't consider the resident's incident to be a fall. RN #107 then said, they later spoke with other registered staff members and Administrator #100. The registered staff members and the Administrator all said resident #001's incident was considered a fall.

Director of Care (DOC) #101 said, they did consider the resident's incident to be a fall and that was why they submitted a Critical Incident Report to the MLTC. They also said an assessment of the resident should have been completed before moving the resident.

Administrator #100 and DOC #101 both said, it was their expectation that any resident be assessed when they have fallen and before they are moved, and it was their expectation that registered staff complete all required assessments on PCC before they leave the Long Term Care Home at the end of their shift. There was an increased risk to resident #001 when the resident fell and was not assessed by registered staff.

Sources: Resident #001's critical incident report and clinical records; the home's policy "Resident Falls", number OTP-OPFP-8.6 (effective May 2017); and interviews with the Administrator, DOC and other staff. [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 by ensuring that all staff members are aware of the home's expectation and definition of a resident fall and all residents who have fallen are assessed by a registered staff member, to be implemented voluntarily.

Issued on this 7th day of June, 2021

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

Original report signed by the inspector.