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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
Oct 19, 2021	2021_790730_0034	010507-21	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

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): October 13 and 14, 2021.

The following Critical Incident System (CIS) intake was completed within this inspection:

Related to falls prevention and management:
Critical Incident Log: 2802-000005-21/ Log # 010507-21

An IPAC inspection was also completed during the Critical Incident System inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), a Screener, the Environmental Services Manager (ESM), the Registered Dietitian (RD), a Nurse Practitioner (NP), a Registered Nurse (RN), a Registered Practical Nurse (RPN), and a Personal Support Worker (PSW).

The inspector also observed resident rooms and common areas, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, and reviewed policies and procedures of the home.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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. 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

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 residents #001, #002, and #003 received skin assessments by a member of the registered nursing staff upon return from hospital.

Resident #001 was admitted to hospital and returned with an area of impaired skin integrity. No skin assessments were documented for resident #001 immediately upon their return.

Residents #002 and #003 were admitted to hospital and no skin assessments were documented upon their returns.

A Registered Practical Nurse (RPN) said that it was the expectation of the home that a skin assessment would be completed by a member of the registered nursing staff on the

same shift that a resident returned from hospital, or at minimum within 24 hours. They said that resident #001 had impaired skin integrity upon their return from hospital and should have immediately been assessed but was not.

A Registered Nurse (RN) said that residents #002 and #003 were at risk for impaired skin integrity. They said that skin assessments should have been completed for the residents upon return from hospital but were not.

There was a risk of harm to residents #001, #002, and #003 when skin assessments were not completed by a member of the registered nursing staff upon return from hospital.

Sources: Resident #001, #002, and #003's clinical records including assessments, progress notes, and census history, and interviews with a RPN, a RN, and other staff. [s. 50. (2) (a) (ii)]

2. The licensee has failed to ensure that residents #001, #002, and #003, who were exhibiting altered skin integrity, were reassessed at least weekly by a member of the registered nursing staff.

Residents #001, #002, and #003 had areas of impaired skin integrity. Weekly reassessments of the areas were not completed consistently.

A Registered Practical Nurse (RPN) said that nursing staff were to complete assessments of areas of altered skin integrity at least weekly and that resident #001 was not reassessed at least weekly.

A Registered Nurse (RN) said that resident #002 and #003's areas of altered skin integrity were not reassessed at least weekly.

There was risk that resident #001, #002, and #003's areas of altered skin integrity would worsen in the absence of weekly skin assessments.

Sources: Clinical records for resident #001, #002, and #003, including progress notes, skin assessments, and care plans, and interviews with a RPN, a RN and others staff. [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 that when a resident returns from hospital they receive a skin assessment by a member of the registered nursing staff and that areas of impaired skin integrity are reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #2: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in a resident plan of care related to falls prevention and management was provided to the resident as specified in the plan.

The resident was at high risk for falls. The resident had interventions in their plan of care related to falls prevention. When the resident sustained a fall it was documented in the "Post Fall Investigation Assessment" that two of the interventions documented in the plan of care were not in place.

Inspector #730 observed that the resident did not have a specified intervention in place, which was documented in their plan of care.

A Registered Practical Nurse (RPN) said that the resident should have had their falls prevention interventions in place as specified in their care plan.

There was a risk of harm to the resident as a result of their falls prevention interventions not being in place as per their plan of care.

Sources: Resident clinical record, observations of the resident, and interviews with a RPN and other staff. [s. 6. (7)]

2. The licensee failed to ensure that a resident's plan of care related to transferring was reviewed and revised when their care needs changed.

A resident was most recently assessed by the home's Physiotherapist to require a specified style of transfer. Review of the resident's most recent plan of care indicated that the resident required a different style of transfer.

A Registered Practical Nurse (RPN) said that the expectation of the home was that a resident's plan of care was revised immediately when their care needs changed. They said that the resident's plan of care was not revised when their care needs related to transferring changed.

The home's policy titled "Transfer, Lift, Sling Assessment" (Updated June 30, 2021) stated that it was the role of the home's Physiotherapist to assess transfer status for residents and that any changes to transfer status would be communicated to the registered staff and updated in the resident's plan of care.

There was minimal risk of harm to the resident as a result of their plan of care not being revised to reflect their most recent transfer status.

Sources: Resident clinical record; the home's policy titled "Transfer, Lift, Sling Assessment" (Updated June 30, 2021), and interviews with a RPN and other staff. [s. 6. (10) (b)]

Issued on this 19th day of October, 2021

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

Original report signed by the inspector.