Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: May 2, 2023	
Inspection Number: 2023-1292-0002	
Inspection Type: Proactive Compliance Inspection	
Licensee: Wildwood Care Centre Inc.	
Long Term Care Home and City: Wildwood Care Centre, St Marys	
Lead Inspector Melanie Northey (563)	**Inspector Digital Signature** Melanie Northey Digitally signed by Melanie Northey Date: 2023.05.02 15:33:13 -04'00'
Additional Inspector(s) Debbie Warpula (577)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 18, 19, 20, 21, 24, 25, and 26, 2023

The following intake(s) were inspected:

- Intake: #00085655 - 2023 PCI Inspection

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

Non-compliance with: FLTCA 2021, s. 6 (1) (c)

The licensee has failed to ensure that the resident's plan of care provided clear direction.

Rationale and Summary
The Resident Care Planning policy indicated that the care plan was to accurately reflect the current needs, complications, and care requirements of each resident.

The resident's care plan did not provide clear direction for a specific activity of daily living. Personal Support Workers (PSWs) indicated specific care was provided, but the care plan stated otherwise.

The Director of Care (DOC) and the Inspector reviewed the resident's assessments and care plan, and the DOC stated that the care plan provided unclear directions related to the resident's specific care needs.

There was low risk to the resident at the time of inspection as the resident received the care they required based on assessments.

Sources: Interviews with PSWs, the resident and the DOC, record review of the resident's care plan and quarterly assessments.
[577]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.

The licensee failed to ensure a written record related to each annual evaluation included a summary of the changes made and the date that those changes were implemented with in respect of each of the interdisciplinary programs required under section 53 of this Regulation.

Rationale & Summary
A) Ontario Regulation 246/22, s. 53 (1) states, "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain."

The Program: Pain Management annual evaluation documented changes to existing practices and for the summary of the changes made, there were no dates that those changes were implemented.

The Director of Care (DOC) verified the pain management program was reviewed in 2022, and the summary of the changes made did not include the date those changes were implemented.

B) Ontario Regulation 246/22, s. 53 (1) states, "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury."

The Program: Falls Prevention and Management annual evaluation documented changes to existing practices and for the summary of the changes made, there were no dates that those changes were implemented.

The DOC verified the fall prevention and management program was reviewed in 2022, and the summary of the changes made did not include the date those changes were implemented.

C) Ontario Regulation 246/22, s. 53 (1) states, "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions."

The Program: Healthy Living, Healthy Skin annual evaluation documented changes to existing practices and for the summary of the changes made, there were no dates that those changes were implemented.

The DOC verified the skin and wound program was reviewed in 2023, and the summary of the changes made did not include the date those changes were implemented.

Sources: Program: Fall Prevention and Management annual evaluation, Program: Pain Management annual evaluation, Program: Healthy Living, Healthy Skin annual evaluation, Resident Falls and Post Fall Assessment Policy, Pain Management Program Policy, Healthy Skin Program Introduction and Objectives Policy, and an interview with the DOC.
[563]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 7.

The licensee failed to ensure that the continuous quality improvement (CQI) committee was composed

of at least one employee of the licensee who was a member of the regular nursing staff of the home.

Rationale & Summary
The most recent Health Advisory Meeting did not include at least one employee of the licensee who was a member of the regular nursing staff of the home.

The Administrator verified there were monthly meetings with the registered nursing staff and Personal Support Workers (PSW) were also attended by residents including the Residents' Council representative. However, the Health Advisory meeting quarterly was the CQI committee, and the monthly meetings were information sessions for staff, family, and residents.

The Quality Manager and Director of Care (DOC) verified the Health Advisory meetings quarterly lacked the attendance of a registered staff member. The DOC stated the monthly meetings with the staff and residents was the home's opportunity to share CQI information, but it was not the meeting of the continuous quality improvement committee.

Sources: Health Advisory Meeting minutes, Terms of Reference - Quality Improvement Committee Policy, and interviews with staff and Residents' Council President.
[563]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.

The licensee failed to ensure that the continuous quality improvement (CQI) committee was composed of at least one employee of the licensee who had been hired as a Personal Support Workers (PSW) or provides personal support services at the home and meets the qualification of PSWs .

Rationale & Summary
The most recent Health Advisory Meeting did not include at least one employee of the licensee who was a PSW.

The Administrator verified there were monthly meetings with the registered nursing staff and Personal Support Workers (PSW) were also attended by residents including the Residents' Council representative. However, the Health Advisory meeting quarterly was the CQI committee, and the monthly meetings were information sessions for staff, family, and residents.

The Quality Manager and the DOC verified the Health Advisory meetings quarterly lacked the attendance of a PSW. The DOC stated the monthly meetings with the staff and residents was the home's

opportunity to share CQI information, but it was not the meeting of the continuous quality improvement committee.

Sources: Health Advisory Meeting minutes, Terms of Reference - Quality Improvement Committee Policy, and interviews with staff and Residents' Council President.
[563]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 9.

The licensee failed to ensure that the continuous quality improvement (CQI) committee was composed of at least one member of the home's Residents' Council.

Rationale & Summary
The most recent Health Advisory Meeting did not include at least one employee of the licensee who was one member of the home's Residents' Council.

The Administrator verified there were monthly meetings with the registered nursing staff and Personal Support Workers (PSW) were also attended by residents including the Residents' Council representative. However, the Health Advisory meeting quarterly was the CQI committee, and the monthly meetings were information sessions for staff, family, and residents.

The Quality Manager and the DOC verified the Health Advisory meetings quarterly lacked the attendance of one member of Residents' Council. The DOC stated the monthly meetings with the staff and residents was the home's opportunity to share CQI information, but it was not the meeting of the continuous quality improvement committee.

The Residents' Council President stated they were not a member of the continuous quality improvement committee and stated they do not recall helping to identify and make recommendations about specific priority areas, but that residents could talk about concerns at Residents' Council. The Residents' Council President was not aware that there was a report on the CQI initiative or what it contained and was not a part of the preparation of the report on the continuous quality improvement initiative.

Sources: Health Advisory Meeting minutes, Terms of Reference - Quality Improvement Committee Policy, and interviews with staff and Residents' Council President.
[563]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (c)

Non-compliance with: O. Reg. 246/22, s. 259 (2) (c)
The licensee has failed to ensure that the training for staff in infection prevention and control (IPAC) required included signs and symptoms of infectious disease.

Rationale and Summary
The IPAC Surge 2023 records for two Personal Support Workers (PSWs), who were hired in 2023, did not include course material on signs and symptoms of infectious disease.

The PSWs stated they had not received education related to signs and symptoms of infectious disease.

The Director of Care (DOC) and the Inspector reviewed the required IPAC modules for Surge learning and the DOC stated that particular course needed to be added to Surge for all staff.

Sources: Interviews with PSWs and the DOC, record review of staff hired after April 11, 2022, Surge IPAC learning report 2023, and Surge course content.
[577]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (e)

Non-compliance with: O. Reg. 246/22, s. 259 (2) (e)
The licensee has failed to ensure that the training for staff in infection prevention and control (IPAC) required included what to do if experiencing symptoms of infectious disease.

Rationale and Summary
The IPAC Surge learning report 2023 for two PSWs, who were hired in 2023, did not include course material on what to do if experiencing symptoms of infectious disease.

PSWs stated they had not received that particular education on Surge.

The DOC and the Inspector reviewed the required IPAC modules for Surge learning and the DOC indicated that particular course needed to be added to Surge for all staff.

Sources: Interviews with PSWs and the DOC, record review of staff hired after April 11, 2022, Surge IPAC

learning report 2023, and Surge course content.
[577]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (h)

Non-compliance with: O. Reg. 246/22, s. 259 (2) (h)
The licensee has failed to ensure that the training for staff in infection prevention and control (IPAC) required included handling and disposing of biological and clinical waste.

Rationale and Summary
The IPAC Surge 2023 records for two PSWs, who were hired in 2023, did not include course material on handling and disposing of biological and clinical waste.

PSWs stated they had not received education related to the handling and disposing of biological and clinical waste.

The DOC and the Inspector reviewed the required IPAC modules for Surge learning and the DOC stated that particular course needed to be added to Surge for all staff.

Sources: Interviews with PSWs and the DOC, record review of staff hired after April 11, 2022, Surge IPAC learning report 2023, and Surge course content.
[577]