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: June 16, 2023	
Inspection Number: 2023-1292-0003	
Inspection Type: Critical Incident System	
Licensee: Wildwood Care Centre Inc.	
Long Term Care Home and City: Wildwood Care Centre, St Marys	
Lead Inspector Tracey Delisle (741863)	**Inspector Digital Signature** Tracey DeLisle Digitally signed by Tracey DeLisle Date: 2023.06.20 10:31:38 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 7 - 9, 2023

The following intake(s) were inspected:

- Intake: #00085627: Fall resulting in injury.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

COMPLIANCE ORDER CO #001: Plan of Care

NC #001 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The Licensee shall:

1. Ensure the staff are following the plan of care for a resident as it relates to a specific intervention.

Grounds

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Rationale and Summary

It was inspected that a resident had a fall resulting in an injury. According to the care plan prior to the fall, the staff were to ensure there was a specific intervention was provided. During the inspection, it was confirmed in the investigation notes and the interview with staff that the intervention was not provided for the resident the day of the fall.

Failure to ensure that resident's plan of care for ensuring the intervention was followed, put the resident at risk of injury from falls and subsequently sustained an injury.

Sources: Interview with staff, Resident's care plan, progress notes, Falls Risk Screen, CI investigation notes, Resident Falls and Post Fall Assessment Policy #OTP-FP-7.4, MORSE Assessment, Post Fall Assessment
[741863]

This order must be complied with by: June 26, 2023

COMPLIANCE ORDER CO #002: Safe Lift and Transfer

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The Licensee shall:

1. Re-train all Registered Nursing Staff in person on Safe Lift and Transfer Policies; and
2. Document the education, including the date and the staff member providing the education

Grounds

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when transferring a resident from the floor after a fall.

In accordance with O. Reg 246/22 s. 11(1)(b), the license failed to ensure the long-term care home to have, institute or otherwise put in place any policy or protocol, the licensee is required to ensure that the policy or protocol is complied with.

Specifically, the staff did not comply with the Policy; Principles of Lifting and Transferring to ensure safe transferring techniques were followed when transferring a resident.

Rationale and Summary

It was inspected, that a resident had a fall, and it was confirmed in the LTCH's investigation notes and interviews with staff that two to three staff manually picked the resident up off the floor without the use of a mechanical lift.

The staff did not use techniques as per the LTCH's Principles of Lifting and Transferring Policy, and as per the Resident Falls and Post Fall Assessment Policy, the resident "should be transferred to bed for a more thorough investigation". The administration staff confirmed they were trained on this technique but did not use the mechanical lift in this case.

Interviews with staff during the inspection, also confirmed staff intermittently do not follow this policy when lifting other residents off the floor.

Failure to properly lift and transfer a resident, put the resident at risk for further injury.

Sources: Staff interviews, Resident care plan and progress notes, Falls Risk Screen, LTCH's investigation notes, Policy #CS-6.2 Mandatory Lift and Transfer Procedure, Policy #CS-6.1 Principles of Lifting and Transferring, Resident Falls and Post Fall Assessment Policy
[741863]

This order must be complied with by: July 17, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.