Ontario

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

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

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

Original Public Report

Report Issue Date: April 29, 2024	
Inspection Number: 2024-1292-0001	
Inspection Type: Complaint Critical Incident	
Licensee: Omni Healthcare (Wildwood) Limited Partnership by its general partner Omni Healthcare (Wildwood) GP Ltd.	
Long Term Care Home and City: Wildwood Care Centre, St Marys	
Lead Inspector Peter Hannaberg (721821)	**Inspector Digital Signature**
Additional Inspector(s) Loma Puckerin (705241)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 17, 18, 19, 22, 23, 2024.

The following intake(s) were inspected:

- Intake #00110252 / Critical Incident (CI) 2802-000002-24 was related to a resident fall,
- Intake #00110320 was a complaint related to improper care of residents by staff,
- Intake #00111719 / CI 2802-000005-24 was related to a resident fall of resident, and
- Intake #00112000 / CI 2802-000006-24 was related to a resident to resident altercation.

The following intakes were also completed during this inspection:

- Intake #00108718 was another complaint with the same concerns as intake #00110320,
- Intake #00114507 / CI 2802-000008-24 was related to a resident fall, and
- Intake #00114039 / CI 2802-000007-24 was also related to a resident fall.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
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 (7)
Plan of care
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.

The licensee has failed to ensure that the care set out in the plan of care was provided to two residents as specified in their plans.

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Rationale and Summary
Progress notes showed that two residents who were experiencing responsive behaviours and a Registered Nurse (RN) implemented an intervention for them.

The Director of Care (DOC) stated in an interview that other strategies which were already identified in their care plan should have been trialed before this intervention was implemented.

The residents were at risk for further injury when this intervention was used.

Sources: progress notes and interview with the DOC.
[721821]

WRITTEN NOTIFICATION: Administration of drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (3) (b) (ii)
Administration of drugs
s. 140 (3) Subject to subsections (4) and (6), the licensee shall ensure that no person administers a drug to a resident in the home unless,
(b) where the administration does not involve the performance of a controlled act under subsection 27 (2) of the Regulated Health Professions Act, 1991, the person is,
(ii) a personal support worker who has received training in the administration of drugs in accordance with written policies and protocols developed under subsection 123 (2), who, in the reasonable opinion of the licensee, has the appropriate skills, knowledge and experience to administer drugs in a long-term care home, who has been assigned to perform the administration by a member of the registered nursing staff of the long-term care home and is under the supervision of that member in accordance with any practice standards and guidelines issued by the College of Nurses of Ontario, and who,
(A) meets the requirements set out in subsection 52 (1) or who is described in

subsection 52 (3), or
(B) is an internationally trained nurse who is working as a personal support worker. O. Reg. 66/23, s. 28 (1).

The licensee has failed to ensure that no person administered a drug to a resident unless that person was a personal support worker who had received training in the administration of drugs in accordance with the home's policies and under the supervision of a member of the registered nursing staff.

Rationale and Summary

In April 2024, the Ministry of Long-Term Care was notified that a Registered Nurse (RN) was allegedly giving medications to a Personal Support Worker (PSW) for administration. After review of the home's investigation notes and an interview with the PSW, it was confirmed that they had administered medications to a resident. The PSW stated that they had not been trained on the home's medication administration polices and protocols, nor on the College of Nurses Best Practice Guidelines for medication administration. They also stated they were not supervised when these medications were administered, therefore the RN would not have been able to confirm if the resident actually took them.

During an interview with the Director of Care (DOC), they stated that none of the PSWs employed by the home have been trained on medication administration and that they would expect that the registered nursing staff would be administering drugs.

There was a risk to the resident that their medications would not be administered as specified by the prescriber when they were given by a PSW without being trained on the home's policies and nursing best practices.

Sources: staff interviews and review of the home's investigation notes.
[721821]