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

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Public Report

Report Issue Date: January 15, 2025
Inspection Number: 2025-1292-0001
Inspection Type: 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

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 13-15, 2025.

The following intake was inspected:

- Intake: #00132729 - Critical Incident (CI) #2802-000028-24 related to a resident fall with injury

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary;

The licensee has failed to ensure a resident's plan of care was reviewed and revised when the resident's care needs changed and when the care set out in the plan was no longer necessary. It was observed that a resident was using a type of specialty chair and did not have a falls prevention intervention in place, however the resident's plan of care did not include the use of the chair and indicated the falls prevention intervention was required.

On January 13, 2025, the resident's plan of care was updated to include the specialty chair and removed the need for the falls prevention intervention.

Sources: observations of a resident, review of a resident's plan of care, and interviews with Personal Support Worker #105, and the Director of Care (DOC).

Date Remedy Implemented: January 13, 2025

WRITTEN NOTIFICATION: Plan of care

NC #002 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 the care set out in the falls prevention plan of care for a resident was provided to the resident as specified in the plan. A resident's plan of care stated they were to have a falls prevention intervention in place, however the intervention was not in place when the resident fell and sustained an injury.

Sources: review of CI #2802-000028-24, a resident's plan of care, post-fall assessment of a resident, and a resident's progress notes, and an interview with the DOC.

WRITTEN NOTIFICATION: Required programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) 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 licensee has failed to comply with the home's falls prevention and management program when a Head Injury Routine (HIR) was not restarted when a resident had a second fall within 72 hours of a first fall.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure written policies developed for the falls prevention and management program were complied with.

Specifically, the home's policy indicated a second HIR was to be initiated to reset the HIR scheduled completion times if the resident fell again within 72 hours, which did not occur when a resident had two falls within 72 hours.

Sources: review of a resident's progress notes, HIR form for a resident, and the home's falls prevention policy, and an interview with the DOC.