Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 2, 2018	2017_607523_0037	021975-17	Resident Quality Inspection

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 INC.
100 ANN STREET P.O. BOX 2200 ST. MARYS ON N4X 1A1

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ALI NASSER (523), AMIE GIBBS-WARD (630)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): December 19, 20, 21 and 22, 2017.

The following Critical Incident inspections were completed during this RQI:
Log #021480-16 CI # 2802-000008-16 related to altercation between residents.
Log #033367-16 CI #2802-000012-16 related to alleged altercation between residents.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Pharmacist, four Registered staff members, three Personal Support Workers, Residents' Council member, Family Council member, three family members and 20 residents.

During the course of the inspection, the inspector(s) toured all resident home areas. Observed medication rooms, medication administration pass and a narcotic medication count, the provision of resident care, recreational activities, resident/staff interactions, infection prevention and control practices and reviewed resident clinical records, posting of required information and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

5 WN(s)
5 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	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 a resident was reassessed and the plan of care was reviewed and revised when the resident's care needs changed.

A clinical record review for a resident showed the following:
A progress note completed on a certain date showed that the staff voiced concerns regarding an area with altered skin integrity, the nurse cleansed the area.

A progress note completed 10 days after the first note showed that two PSWs approached the nurse about an area with altered skin integrity, treatment applied, continue to monitor.

A progress note completed two days later showed that dressing changed on an area with altered skin integrity, area cleansed and treatment applied.

A progress note completed nine days later showed that resident was assessed, area with altered skin integrity was noted, treatment will be added to EMAR to ensure staff were monitoring and care provided as needed.

A management team member said in an interview, the expectation was for the care plan and Treatment Administration Record (TAR) or Medication Administration Record (MAR) be updated accordingly to reflect changes in the resident’s care needs.
A further review of the clinical record with the management team member showed that the resident’s plan of care was not reviewed or revised.

Two management team members said that it was the home’s expectation that the resident would have been reassessed and the plan of care reviewed and revised when the resident’s care needs had changed.

The licensee has failed to ensure that a resident was reassessed and the plan of care was reviewed or revised when the resident exhibited altered skin integrity and the resident's care needs were changed. [s. 6. (10) (b)]

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 the resident is reassessed and the plan of care is reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

Ontario Regulation 79/10 s. 30 (1) stated "Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required".

Ontario Regulation 79/10 s. 48 (1) stated "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 ulcers, and provide effective skin and wound care interventions".

A review of home's policy titled Skin Assessment, policy #HLHS-SW-3.3, effective date March 2013, procedure #7 stated "complete Braden Scale for predicting Pressure sore risk within 24 hours of admission.
Very high-high risk = minimum monthly.
Moderate risk = every three months.
Low/no risk = every six months or if there is a change in the residents status".

A review of the Braden scale assessment completed for a resident showed that the resident was identified as high on a certain date in and for the next four quarterly assessments.

Two management team members said that the resident was identified on a specific date as a high risk for skin breakdown. The expectation was for the resident to have the Braden Scale Assessment completed every month since the date, as they were high risk for skin breakdown.

The licensee has failed to ensure that the Skin Assessment policy was complied with when the staff failed to complete monthly Braden Scale Assessment for a resident with high risk for skin breakdown. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

Ontario Regulation 79/10 s. 114 (2) stated "The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home" .

A review of Medical Pharmacies policy titled Shift Change Monitored Drug Count, policy # 6-6, reviewed February 2017, procedure # 2 showed: "Two staff (leaving and arriving),

together:
a. Count the actual quantity of medications remaining.
b. Record the date, time, quantity of medication and sign in the appropriate spaces on the shift change monitored medication count form.
c. Confirm actual quantity is the same as the amount recorded on the individual monitored medication record for PRN, liquid, patches or injectable".

On a certain date an observation of the shift change narcotic count showed that a RN was counting the medications and calling the count out, another RN was documenting the count on the form.

The two nurses said that they did not count the actual quantity together and they did not confirm the count together before documenting the number on the form.

In an interview a Pharmacist said that the expectation was for the count to be completed at the shift change by two nurses, leaving and arriving nurse. The count would be completed and confirmed by the two nurses, then that count would be documented and signed by the two nurses.

A management team member said that the expectation was the two nurses, incoming and outgoing would complete the count, document and sign on the count together and that the staff would comply with the home's policy.

The licensee has failed to ensure that the Shift Change Monitored Drug Count policy was complied with by having two nurses, incoming and outgoing complete the count, document and sign on the count together. [s. 8. (1) (b)]

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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to keep a written record relating to the annual evaluation of the Skin and Wound Care Program that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A review of the OMNI Healthcare Policy/Program Evaluation dated December 2017, showed that the review for the program did not include the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Two management team members said in an interview that the a specific management team member completed the required program evaluation on their own by providing an overview of the programs. They said that the management team member did not complete the annual evaluation of the program as per the legislative requirements.

The Two management team members said that they will be reviewing and evaluating the program with the interdisciplinary team as required.

The licensee has failed to keep a written record relating to the annual evaluation of the Skin and Wound Care Program that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. [s. 30. (1) 4.]

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 keep a written record relating to the annual evaluation of the Skin and Wound Care Program that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes are implemented, to be implemented voluntarily.

WN #4: 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,
(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 a resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A clinical record review for a resident showed the following:

A progress note completed on a certain date showed that the staff voiced concerns to the nurse regarding an area with altered skin integrity, the nurse cleansed the area.

A progress note completed 10 days after the first note showed that two PSWs approached the nurse about an area with altered skin integrity, treatment applied, continue to monitor.

A progress note completed two days later showed that dressing changed on an area with altered skin integrity, area cleansed and treatment applied.

A progress note completed nine days later showed that resident was assessed, area with altered skin integrity was noted, treatment will be added to EMAR to ensure staff were monitoring and care provided as needed.

There was no evidence that when the resident exhibited an altered skin integrity they received a skin assessment by a member of the registered nursing staff using a clinically appropriate tool that was specifically designed for skin and wound assessment.

A management team member said in an interview, the expectation was that a Head to Toe Skin Assessment and a Braden Scale Assessment would be completed once an altered skin integrity had been identified. The care plan and Treatment Administration Record (TAR) or Medication Administration Record (MAR) would be updated accordingly.

A further review of the clinical record with the management team member showed that there were no Head to Toe skin assessment or Braden Scale assessment completed when the new altered skin integrity was identified. There were no changes to the resident's TAR, MAR or care plan were identified.

Two management team members said that it was the home's expectation that the Head to Toe skin assessment and Braden Scale assessment would be completed when the new altered skin integrity was identified.

The licensee has failed to ensure that when a resident exhibited altered skin integrity, the resident did not receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

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 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision-maker (SDM) , if any and the resident's attending physician or the registered nurse in the extended class attending the resident.

A review of medication incident report submitted on a certain date showed that a resident received a medication when that medication was to be held.
No resident, resident's SDM or physician notifications noted on the report.

A review of medication incident report submitted on a certain date showed that a resident did not receive their medication.
No resident, resident's SDM or physician notifications noted on the report.

A review of medication incident report submitted on a certain date showed that a resident did not receive their medication for multiple days as it was out of stock. medication was signed as given.
No resident, resident's SDM or physician notifications noted on the report.

A management team member reviewed the medication incident forms and the clinical records for the specific residents and said that there was no documentation in the progress notes that the residents, Residents' SDMs or the physicians were notified of the incidents. They said in an interview that the expectation was for staff to notify the resident, SDM if any and physician of the medication incident.

The Pharmacist said in an interview that the expectation was for staff to inform resident, the resident’s SDM if any and the physician of all medications incidents.

The licensee has failed to ensure that medication incidents involving certain residents, were reported to the residents, the residents’ SDMs if any and their physicians. [s. 135. (1)]

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 every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's SDM, if any and the resident's attending physician or the registered nurse in the extended class attending the resident, to be implemented voluntarily.

Issued on this 4th day of January, 2018

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

Original report signed by the inspector.