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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
Jun 6, 2018	2018_607523_0008	016394-16, 017176-16, 020480-16, 020742-16	Critical Incident System

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
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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 15 and 16, 2018

The following Critical Incidents were inspected during this inspection:

Critical Incident intake Log # 016394-16, CIS # 2802-000005-16 / SAC #12222 related to alleged visitor to resident abuse.
Critical Incident intake Log # 017176-16, CIS # 2802-000006-16 related to alleged staff to resident abuse.
Critical Incident intake Log # 020480-16, CIS # 2802-000007-16 / SAC 12642, related to resident's attempt to self harm.
Critical Incident intake Log # 020742-16, CIS # 2802-000001-16, related to a resident's fall.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, three Personal Support Workers and two registered staff members.

The inspector(s) also observed residents and care provided to them, observed staff resident interactions, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home and internal investigation records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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 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, including skin breakdown, pressure ulcers, skin tears or wounds received 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.

The home submitted a specific Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a specific related to a resident's incident that resulted in an injury for which the resident was transferred to hospital.

A review of the CIS showed that the resident was found with injuries to specific limbs.

A clinical record review for the resident showed that the resident sustained injuries to specific limbs on a specific date, resident was transferred to hospital and returned home on a later date.

A clinical record review revealed that the resident received a skin and wound assessment 14 days after returning from hospital.

The Director of Care said in an interview that the resident did not receive a skin assessment when they sustained new wounds to specific limbs. The DOC said that it was the home's expectation to complete a skin assessment using the head to toe skin assessment tool when new skin integrity concerns were noted. [s. 50. (2) (b) (i)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that when unable to determine after an incident whether resident's injury had resulted in a significant change in the resident's health condition, to inform the Director of the incident no later than three business days after the occurrence of the incident.

The home submitted a specific Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a specific related to a resident's fall that resulted in an injury for which the resident was transferred to hospital.
A review of the CIS report showed that the resident had a fall and was transferred to hospital on a certain date, the hospital informed the home that the resident passed away 6 days later, the CIS was submitted 2 days after that.

A clinical record review for the resident showed the home was informed by the hospital staff 2 days after admission that the resident had a significant injury and the resident would not have a surgery.

In an interview the DOC acknowledged that they had three business days after the date of the occurrence to inform the Director of the incident that resulted in the transfer of a resident to the hospital and whether they were able to confirm a change in condition or not able to do so at that time.
The Administrator said in an interview that they did not inform the Director of the incident that resulted in an injury and transfer to hospital as per the Legislative requirements. [s. 107. (3.1) (b)]

Issued on this 7th day of June, 2018

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

Original report signed by the inspector.