Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 17, 2019	2019_736689_0027	019569-19, 019584-19	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

CASSANDRA ALEKSIC (689)

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): October 10 & 11, 2019.

The following intake was completed in this Critical Incident System Inspection:

Critical Incident Log #019569-19 / CI 2802-000013-19, related to falls prevention; and
Critical Incident Log #019584-19 / CI 2802-000014-19, related to plan of care.

During the course of the inspection, the inspector(s) spoke with the Administrator, a Registered Nurse, Registered Practical Nurses, and Personal Support Workers.

The inspector also reviewed clinical health records and made resident observations during the inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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	Légende 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and other who provided direct care to the resident.

Critical Incident System (CIS) report #2802-000014-19 submitted to the Ministry of Long-Term Care (MOLTC) on a specific date documented an incident resulting in a change in condition. The report stated that resident #001 had health complications and the Registered Nurse (RN) on duty determined that further intervention was indicated. The report stated that the RN contacted the resident's Power of Attorney (POA) and suggested that Emergency Medical Services (EMS) be contacted to assist. The report stated that when EMS attended the home, the resident had a change in condition. EMS requested a copy of the residents Do Not Resuscitate (DNR) Confirmation Form, the RN was unable to locate the document and EMS stated that Cardiopulmonary Resuscitation (CPR) would be started without the signed DNR form. The report said that some confusion ensued related to the absence of the signed DNR form.

The clinical health record for resident #001 was reviewed in Point Click Care (PCC). The "Code Status" in PCC stated: "Level 2 - Comfort Measures with Additional Treatment Available at Wildwood Care Centre". The paper chart included a form "Advance Care Planning and Directives" which indicated the resident and/or substitute decision maker's (SDM) wishes/directive related to the level of treatment that should be used in the event of a life threatening illness or injury. The form indicated "Comfort measures with additional treatment available at the home. In addition to the above, Artificial Nutrition (giving nutrition through a tube in the nose or stomach and Artificial Hydration (giving fluids through a tube inserted under the skin) may be provided to the Resident. No cardiopulmonary resuscitation (CPR) will be administered to the Resident."

The paper chart included a "Do Not Resuscitate Confirmation Form" dated and signed on the date of the incident. There was no DNR confirmation forms completed prior to the incident date in the resident's chart.

During an interview on a specific date, Administrator #100 stated that Advance Care Directives (ACD), including DNR status were to be determined on admission or annually during resident care conferences or anytime if the resident or family wishes changed. The Administrator stated that the ACD and DNR forms would be maintained in the resident's paper chart. Administrator #100 said on the date of the incident, resident #001 had a change in condition when EMS arrived at the home and when they asked for the

DNR form, staff were not able to locate it. The Administrator said the original copy may have been sent with the resident during a previous transfer with paramedics. The Administrator stated that CPR was initiated by EMS and during that time, the RN spoke with the resident's SDM and completed a new DNR form. When asked if the resident had a completed DNR confirmation form available as part of their plan of care prior to the incident date to direct staff on what treatment to provide to the resident, the Administrator said no. The Administrator stated that they would expect that the resident would have ACD and code status documentation available in their plan of care on the day of the incident.

During an interview on a specific date, RN #108 stated on the date of the incident, they assisted resident #001 who was observed to have health complications. The RN said that the resident was to have comfort measures as per the level two on the residents ACD, but since they were having complications, they were considered to not be experiencing comfort measures. RN #108 said that they called EMS to assist the resident with providing emergency medical care. The RN said that when EMS arrived, the resident had a change in condition and wanted to initiate CPR. The RN said that they looked for the DNR form in the residents chart, but could not locate it and CPR was initiated. RN #108 said that they spoke with the resident's SDM, located a blank DNR form, filled it out and told EMS to stop CPR. RN #108 stated that ACD and DNR forms were completed for residents on admission. The RN said that the DNR confirmation form for resident #001 was not in the chart on the day of the incident. When asked if the residents written plan of care provided clear direction to the staff for what actions to take regarding the residents' care directives and do not resuscitate status, the RN said no, there was no clear direction for them on what to do for the resident and CPR was initiated.

The Administrator shared that after the incident, registered staff were directed to complete a chart audit in the home for the presence of ACD and DNR forms for all residents.

On a specific date, a record review was completed of ACD and DNR forms in paper charts as well as code status in PCC. The record review for resident #002 showed:
-a specific Initial Admission Date
-Code status in PCC was blank
-ACD stated "comfort measures only" which indicated no CPR would be administered to the resident and DNR form was present.
Both documents were completed by Registered Practical Nurse (RPN) #103 on a specific

date.

During an interview on a specific date, Registered Practical Nurse (RPN) #103 said that they had reviewed all the resident charts in the home to ensure that the appropriate documentation, including ACD and DNR forms were completed and located within the charts. When asked if they had completed the forms for resident #002, the RPN said yes. RPN #103 said that the ACD and DNR forms were provided to the resident and their family when they were first admitted to the home, however the resident's family had never returned them. The RPN stated that the forms were completed on a specific date when the resident's family member came into the home as part of the chart review. When asked what the direction for staff was between the resident's admission date and a specific date related to the residents advance care directives and DNR status, the RPN said that there was no clear direction.

The home's "Advanced Care Planning and Advanced Directive for Treatment" policy #OTP-PC-7.2, with effective date May 2017 stated:
-"On admission, the Directive of Care or their designate shall provide the capable resident or Power of Attorney for Personal Care or Substitute Decision Maker for the incapable resident with the Advance Directives for Treatment form for their review and consideration."
-"Communication systems must ensure that all appropriate staff are aware of the capable resident and Power of Attorney for Personal Care or Substitute Decision Maker's current choice of advance directives for treatment."
-"The care plan will be updated on the chosen level of care chosen by the capable resident, and the last known wishes of the incapable resident as outlined by the Substitute Decision Maker or Power Of Attorney for personal care."

The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided care to the resident related to Advanced Care Directives and Do Not Resuscitate status for resident #001 and #002. [s. 6. (1) (c)]

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

Issued on this 17th day of October, 2019

[redacted]

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

Original report signed by the inspector.