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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street Suite 403
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 19, 2015	2015_283544_0003	S-000426-14	Critical Incident System

Licensee/Titulaire de permis

WIKWEMIKONG NURSING HOME LIMITED
2281 Wikwemikong Way P.O. Box 114 Wikwemikong ON P0P 2J0

Long-Term Care Home/Foyer de soins de longue durée

WIKWEMIKONG NURSING HOME
2281 Wikwemikong Way P.O. Box 114 Wikwemikong ON P0P 2J0

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

FRANCA MCMILLAN (544)

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): February 2, 3, 2015 related to:

Log # S-000426-14

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Staff, Personal Support Workers (PSWs), Residents and Families.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **1 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. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident has been assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

During a previous Critical Incident Inspection, the home was issued a Voluntary Plan of Correction(VPC) in regards to their Falls Prevention and Management Program specifically relating to the home not conducting post fall assessments using a clinically appropriate instrument specifically designed for falls.

Two Critical Incident reports were reviewed.

Inspector # 544 reviewed the first Critical Incident report which stated that resident # 001 had a fall, sustained a fracture and hit their head. The resident was transferred to hospital, underwent surgery to repair the fracture and returned to the home.

Resident # 001 was later hospitalized as a result of post operative complications related to the surgery to repair their fracture.

Inspector # 544 reviewed the second Critical Incident report which stated resident # 001 had another fall. Staff found resident # 001 lying on the floor. It was reported, by a staff member, who witnessed the fall, that they hit their head. The staff member stated that resident # 001 was attempting to transfer themselves from the wheelchair to the bed. There were no injuries reported at this time however, resident # 001 was hospitalized for another matter.

Inspector # 544 reviewed resident # 001's health care record and plan of care and identified that resident # 001 was to be assisted with cueing for activities, monitored for safety and observed for non-verbal communication for signs of pain and distress. Resident # 001's mode of transfer was with extensive assistance of staff. When in their wheelchair, a seat belt was used for safety as requested by the family. The family also requested full bed rails at bedtime in the "up" position for safety and repositioning.

Resident # 001's had a lengthy history of falling during the course of the year as identified in the progress notes.

With each fall, a Morse Fall Scale risk assessment was completed however, there was no documentation in resident # 001's health care record to support that post fall assessments were completed using a clinically appropriate instrument specifically

designed for falls. Furthermore, the documentation in the progress notes did not include a post fall assessment using a clinically appropriate assessment instrument that is specifically designed for falls and did not indicate that the resident was assessed for 72 hours post fall. This was confirmed by Staff # 102.

Inspector # 544 interviewed the Director of Care (DOC) and Administrator, who both told the inspector, that the home does not use a clinically appropriate assessment instrument that is specifically designed for falls. The DOC told inspector that staff document the resident's fall in the progress notes and then complete a Morse Fall Scale risk assessment. Documentation, under the Risk Management Tab in Point Click Care, (PCC), only identified the names of the residents who have had a fall.

Administrator also told inspector # 544 that the home's Nursing Consultant had stated that documenting the fall in the progress notes was sufficient.

2. Inspector # 544 reviewed the health care record, progress notes and falls history record for resident # 002 and identified that resident # 002 had fallen several times during the course of the year as identified in the progress notes.

With each fall, a Morse Fall Scale risk assessment was completed however, there was no documentation in resident # 002's health care record to support that post fall assessments were completed using a clinically appropriate instrument specifically designed for falls. Furthermore, the documentation, in the progress notes, did not include a post fall assessment using a clinically appropriate assessment instrument that is specifically designed for falls and did not indicate that the resident was assessed for 72 hours post fall. This was confirmed by Staff # 102.

Inspector # 544 interviewed the Director of Care (DOC) and Administrator, who both told inspector, that the home does not use a clinically appropriate assessment instrument that is specifically designed for falls. The DOC told Inspector that staff document the resident's fall in the progress notes and then complete a Morse Fall Scale risk assessment. Documentation, under the Risk Management Tab in Point Click Care, (PCC), only identified the names of the residents who have had a fall.

Administrator also told Inspector # 544 that the home's Nursing Consultant had stated that documenting of the fall in the progress notes was sufficient.

3. Inspector # 544 reviewed the health care record, progress notes and falls history

record for Resident # 003.
Resident # 003's had several falls during the course of the year as identified in the progress notes.

With each fall, a Morse Fall Scale risk assessment was completed however, there was no documentation in resident # 003's health care record to support that post fall assessments were completed using a clinically appropriate instrument specifically designed for falls. Furthermore, the documentation, in the progress notes, did not include a post fall assessment using a clinically appropriate assessment instrument that is specifically designed for falls and did not indicate that resident # 003 was assessed for 72 hours post fall. This was confirmed by Staff # 102.

Inspector # 544 interviewed the Director of Care (DOC) and the Administrator, who both told the inspector, that the home does not use a clinically appropriate assessment instrument that is specifically designed for falls. The DOC told Inspector that staff document the resident's fall in the progress notes and then complete a Morse Fall Scale risk assessment. Documentation, under the Risk Management Tab in Point Click Care, (PCC), only identified the names of the residents who have had a fall.

Administrator also told inspector # 544 that the home's Nursing Consultant had stated that documenting the fall in the progress notes was sufficient. [s. 49. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Inspector # 544 reviewed the home's Falls Prevention and Management Program, Section 3 Resident's Safety, Subsection 3.6, Falls Prevention and Management, Original date: August 2013.
The policy addressed "Evaluation and Monitor Residents for 72 hours after the Fall."
It stated: " Resident should have increased monitoring for the first 72 hours after a fall. Each shift, the nurse should record in the progress notes a review of systems, noting any worsening or improvement of symptoms as well as the treatment provided. Reference to the fall should be clearly documented in the progress note."
Throughout the policy, complete the fall assessment is mentioned several times. There is no mention in the policy regarding post fall assessments.

The above policy also identified risk factors related to medical conditions or medication use may be reflected in abnormal values for any of the following:
1. Vital signs (T,P,R, BP)
2. Head Injury or Neurovital signs
3. Postural blood pressure and apical heart rate
4. Finger stick glucose (for diabetics)
5. Change in condition

There was no documentation in resident # 001's, # 002's and # 003's health care records or progress notes to support the assessment, evaluation and monitoring of these residents for 72 hours after their fall or vital signs, head injury and neurovital signs as per the home's policy.

Resident # 001 post fall assessments did not follow the policy in regards to monitoring and documentation in the progress notes, for 72 hours, especially in light of the fact that on at least two occasions, resident # 001 stated to the staff that they hit their head.

The DOC told the inspector that this documentation could not be found in the progress notes or Resident # 001's, # 002's and 003's health care records and this was not available. [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 20th day of February, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	FRANCA MCMILLAN (544)
Inspection No. / No de l'inspection :	2015_283544_0003
Log No. / Registre no:	S-000426-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 19, 2015
Licensee / Titulaire de permis :	WIKWEMIKONG NURSING HOME LIMITED 2281 Wikwemikong Way, P.O. Box 114, Wikwemikong, ON, P0P-2J0
LTC Home / Foyer de SLD :	WIKWEMIKONG NURSING HOME 2281 Wikwemikong Way, P.O. Box 114, Wikwemikong, ON, P0P-2J0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cheryl Osawabine-Peltier

To WIKWEMIKONG NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Order / Ordre :

The licensee shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Grounds / Motifs :

1. The licensee has failed to ensure that when a Resident has fallen, the resident has been assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

During a previous Critical Incident Inspection, the home was issued a Voluntary Plan of Correction (VPC), in regards to their Falls Prevention and Management Program specifically relating to the home not conducting post fall assessments using a clinically appropriate instrument specifically designed for falls.

Inspector # 544 reviewed a Critical Incident report dated July 23, 2014, which stated that resident # 001 had a fall, sustained a fracture and hit their head. Resident # 001 was transferred to the hospital, underwent surgery to repair the fracture and returned to the home.

Resident # 001 was later hospitalized as a result of post operative complications related to the surgery to repair their fracture.

Inspector # 544 reviewed a Critical Incident report dated September 5, 2014,

which stated resident # 001 had another fall. Staff found resident # 001 lying on the floor in their room. It was reported by a staff member, who witnessed the fall, that resident # 001 also hit their head. The staff member stated that resident # 001 was attempting to transfer from the wheelchair to the bed. Resident # 001 was in excruciating pain, according to the progress notes. There were no injuries reported at this time however, resident # 001 was hospitalized once again for a different matter.

Inspector # 544 reviewed resident # 001's health care record and plan of care and identified that the resident was a high risk for falls. Staff were to assist with cueing for activities, monitoring for safety and observed for non-verbal communication signs of pain and distress. Resident # 001's mode of transfer was with extensive assist of 1-2 persons. When in the wheelchair, a seat belt was used for safety as requested by the family. The family also requested full bed rails in the "up" position at bedtime for safety and repositioning.

Resident # 001's had a long history of falls during the course of the year as identified in the progress notes.

With each fall, a Morse Fall Scale risk assessment was completed however, there was no documentation in resident # 001's health care record to support that post fall assessments were completed using a clinically appropriate instrument specifically designed for falls and did not indicate that the resident was assessed for 72 hours post fall. This was confirmed by Staff # 102.

Inspector # 544 interviewed the Director of Care (DOC) and Administrator, who both told the inspector that the home does not use a clinically appropriate assessment instrument that is specifically designed for falls. The DOC told the inspector that staff document the resident's fall in the progress notes and then complete a Morse Fall Scale risk assessment. Documentation, under the Risk Management Tab in Point Click Care,(PCC), only identified the names of the residents who have had a fall.

Administrator also told Inspector # 544 that the home's Nursing Consultant had stated that documenting the fall in the progress notes was sufficient.

2. Inspector # 544 reviewed the health care record, progress notes and falls history record for resident # 002 and identified that resident # 002 had fallen several times during the course of the year as identified in the progress notes.

With each fall, a Morse Fall Scale risk assessment was completed however, there was no documentation in resident # 002's health care record to support that post fall assessments were completed using a clinically appropriate instrument specifically designed for falls and did not indicate that the resident was assessed for 72 hours post fall. This was confirmed by Staff # 102.

Inspector # 544 interviewed the Director of Care (DOC) and Administrator, who both told the inspector that the home does not use a clinically appropriate assessment instrument that is specifically designed for falls. The DOC told the inspector that staff document the resident's fall in the progress notes and then complete a Morse Fall Scale risk assessment. Documentation, under the Risk Management Tab in Point Click Care,(PCC), only identified the names of the residents who have had a fall.

Administrator also told Inspector # 544 that the home's Nursing Consultant had stated that documenting the fall in the progress notes was sufficient.

3. Inspector # 544 reviewed the health care record, progress notes and falls history record for Resident # 003.
Resident # 003 had several falls within the course of a year as identified in the progress notes.

With each fall, a Morse Fall Scale risk assessment was completed however, there was no documentation in resident # 003's health care record to support that post fall assessments were completed using a clinically appropriate instrument specifically designed for falls and did not indicate that the resident was assessed for 72 hours post fall. This was confirmed by Staff # 102.

Inspector # 544 interviewed the Director of Care (DOC) and Administrator, who both told the inspector that the home does not use a clinically appropriate assessment instrument that is specifically designed for falls. The DOC told the inspector that staff document the resident's fall in the progress notes and then complete a Morse Fall Scale risk assessment. Documentation, under the Risk Management Tab in Point Click Care,(PCC), only identified the names of the residents who have had a fall.

Administrator also told Inspector # 544 that the home's Nursing Consultant had stated that documenting the fall in the progress notes was sufficient. (544)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 20, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 19th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Franca McMillan

Service Area Office /
Bureau régional de services : Sudbury Service Area Office