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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 1, 2017	2017_572627_0015	009548-17, 020902-17	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

SYLVIE BYRNES (627)

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): September 1, 2017.

Critical Incident (CI) submitted to the Director by the licensee alleging resident to resident abuse was inspected during the course of this Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Interim Director of Care (IDOC), Registered Nurse (RN), Registered Practical Nurse (RPN) and Personal Support Workers (PSWs).

The Inspector completed tours of the home, completed resident observations and reviewed documentation.

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

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

1 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Findings/Faits saillants :

The licensee has failed to ensure that all residents in the home were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A Critical Incident (CI) report was submitted to the Director identifying an incident that caused injury to resident #002 for which they were taken to hospital. On a specific date, the home notified the Director of suspected resident to resident abuse relating to the

incident that caused injury to resident #002. An amended CI report submitted to the Director detailed that resident #001 had an unwitnessed altercation with resident #002 which caused resident #002 to sustain numerous injuries.

Inspector #627 interviewed RN #102 who was present at the time of the alleged incident. RN #102 stated that resident #002 had been their normal self in the evening. RN #102 detailed that they had entered resident #001 and #002's room in the evening, and that both residents seemed comfortable and quiet at that time. At a specific time, PSW #105 informed RN #102 that resident #002 had fallen. RN #102 described that when they entered the room, they observed resident #002 on the floor and noted that the resident had numerous injuries. The RN stated that they questioned the injuries of resident #002 being consistent with a fall. They stated that they dismissed the thought of resident #001 having injured resident #002, as they observed resident #001 to have no visible injuries. The RN went on to say that upon entering the room they observed resident #001 close to resident #002, and was attempting to assist the staff in caring for resident #002. When they attempted to question resident #001, the resident had not verbalized anything. The RN had called an ambulance for resident #002 as they were concerned with the extent of the injuries.

In an interview with the Inspector, RPN #103, who was also the Resident Assessment Instrument (RAI) Coordinator, stated that from their observations, resident #001 seemed confused and easily disoriented. RPN #103 went on to state that at a later date, RPN #104 had reported to them that resident #001 had displayed specific responsive behaviours regrading co-residents.. RPN #103 had put in place interventions to address the behaviour.

The Inspector reviewed resident #001's medical records. The resident was admitted to the home on a specific date, a few days prior to the incident. Review of the Community Care Access Centre Function and Social Assessment form and the Health Assessment – Local Health Integration Network (LHIN) form documented that resident #002 displayed no responsive behaviours.

The Inspector observed that the plan of care was updated on after the incident to reflect behavioural triggers for resident #002. Interventions included, but were not limited to, intervene as necessary to protect the rights and safety of others and to monitor and report escalating behaviours. Staff were to monitor resident #001 at specific timed intervals and continue with the interventions put in place to address resident #001's responsive behaviours.

On a specific date and time, the Inspector observed resident #001 outside in a resident area, where many other residents were present. A staff member was observed in the area, then they were observed to leave . The resident remained outside, unsupervised with other residents of the home.

During an interview with the Inspector, PSW #101 stated the resident was being monitored at specific timed intervals to ensure the safety of all residents, but that they were one staff member short at this time.

Inspector #627 interviewed the Interim Director of Care (IDOC). The IDOC stated that they also worked at the Health Center and had been working on a specific date, in the morning when the resident was admitted. They further stated that due to the extent of the injuries, they felt that it had not been caused by a fall. They had called the home and were informed at this time that resident #001 had signs of injury, therefore, they had advised the staff to report the incident to the police and the Ministry of Health and Long-Term Care (MOHLTC). The IDOC went on to say that they had come to the home later in the day to speak with staff upon which they had initiated specific timed monitoring checks on the resident. The resident had been moved to a location in the home to increase monitoring.

During the same interview with the Inspector, IDOC stated that they had attempted to provide specific monitoring for resident #001, however, they had not been successful. They had referred the resident to external Behaviour Supports Ontario (BSO). BSO had completed a visit at a later date, however no new recommendations had been offered. They also were attempting to have resident #001 admitted to a facility for an assessment, however this would take time. The IDOC stated that they had taken all the appropriate steps to have the resident properly assessed. For now, the contingency plan was to continue having timed intervals monitoring checks for resident #001. They informed the Inspector that a full day staff compliment during the day shift included four to six PSWs, one RPN and one RN, however today, two PSWs had left early which left the home with three PSWs only. During the night shift, a full staff compliment included two PSWs and one RN. The IDOC stated that they were still unable to implement specific monitoring of resident #002 and had been unable to contact the physician to discuss additional alternatives.

Additional Required Actions:

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

Issued on this 11th day of September, 2017

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

Original report signed by the inspector.

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : SYLVIE BYRNES (627)

Inspection No. / No de l'inspection : 2017_572627_0015

Log No. / No de registre : 009548-17, 020902-17

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Sep 1, 2017

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. Box114, Wikwemikong, ON, P0P-2J0

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Cheryl Osawabine-Peltier

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2017_562620_0007, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Order / Ordre :

The licensee shall prepare, submit and implement a plan that requires specific supervision of resident #001 at all times.

Grounds / Motifs :

1. The licensee has failed to ensure that all residents in the home were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A Critical Incident (CI) report was submitted to the Director identifying an incident that caused injury to resident #002 for which they were taken to hospital. On a specific date, the home notified the Director of suspected resident to resident abuse relating to the incident that caused injury to resident #002. An amended CI report submitted to the Director detailed that resident #001 had an unwitnessed altercation with resident #002 which caused resident #002 to sustain numerous injuries.

Inspector #627 interviewed RN #102 who was present at the time of the alleged incident. RN #102 stated that resident #002 had been their normal self in the evening. RN #102 detailed that they had entered resident #001 and #002's room in the evening, and that both residents seemed comfortable and quiet at that time. At a specific time, PSW #105 informed RN #102 that resident #002 had fallen. RN #102 described that when they entered the room, they observed resident #002 on the floor and noted that the resident had numerous injuries. The RN stated that they questioned the injuries of resident #002 being consistent with a fall. They stated that they dismissed the thought of resident #001 having injured resident #002, as they observed resident #001 to have no visible injuries. The RN went on to say that upon entering the room they

observed resident #001 close to resident #002, and was attempting to assist the staff in caring for resident #002. When they attempted to question resident #001, the resident had not verbalized anything. The RN had called an ambulance for resident #002 as they were concerned with the extent of the injuries.

In an interview with the Inspector, RPN #103, who was also the Resident Assessment Instrument (RAI) Coordinator, stated that from their observations, resident #001 seemed confused and easily disoriented. RPN #103 went on to state that at a later date, RPN #104 had reported to them that resident #001 had displayed specific responsive behaviours regrading co-residents.. RPN #103 had put in place interventions to address the behaviour.

The Inspector reviewed resident #001's medical records. The resident was admitted to the home on a specific date, a few days prior to the incident. Review of the Community Care Access Centre Function and Social Assessment form and the Health Assessment – Local Health Integration Network (LHIN) form documented that resident #002 displayed no responsive behaviours.

The Inspector observed that the plan of care was updated on after the incident to reflect behavioural triggers for resident #002. Interventions included, but were not limited to, intervene as necessary to protect the rights and safety of others and to monitor and report escalating behaviours. Staff were to monitor resident #001 at specific timed intervals and continue with the interventions put in place to address resident #001's responsive behaviours.

On a specific date and time, the Inspector observed resident #001 outside in a resident area, where many other residents were present. A staff member was observed in the area, then they were observed to leave . The resident remained outside, unsupervised with other residents of the home.

During an interview with the Inspector, PSW #101 stated the resident was being monitored at specific timed intervals to ensure the safety of all residents, but that they were one staff member short at this time.

Inspector #627 interviewed the Interim Director of Care (IDOC). The IDOC stated that they also worked at the Health Center and had been working on a specific date, in the morning when the resident was admitted. They further stated that due to the extent of the injuries, they felt that it had not been caused by a fall. They had called the home and were informed at this time that resident

#001 had signs of injury, therefore, they had advised the staff to report the incident to the police and the Ministry of Health and Long-Term Care (MOHLTC). The IDOC went on to say that they had come to the home later in the day to speak with staff upon which they had initiated specific timed monitoring checks on the resident. The resident had been moved to a location in the home to increase monitoring.

During the same interview with the Inspector, IDOC stated that they had attempted to provide specific monitoring for resident #001, however, they had not been successful. They had referred the resident to external Behaviour Supports Ontario (BSO). BSO had completed a visit at a later date, however no new recommendations had been offered. They also were attempting to have resident #001 admitted to a facility for an assessment, however this would take time. The IDOC stated that they had taken all the appropriate steps to have the resident properly assessed. For now, the contingency plan was to continue having timed intervals monitoring checks for resident #001. They informed the Inspector that a full day staff compliment during the day shift included four to six PSWs, one RPN and one RN, however today, two PSWs had left early which left the home with three PSWs only. During the night shift, a full staff compliment included two PSWs and one RN. The IDOC stated that they were still unable to implement specific monitoring of resident #002 and had been unable to contact the physician to discuss additional alternatives.

The decision to issue this order was based on the severity which was determined to be immediate risk, the scope was determined to be isolated, the compliance history was determined to be ongoing non-compliance in this area of the legislation.
(627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 01, 2017

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 1st day of September, 2017

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Sylvie Byrnes

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