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

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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
May 22, 2018	2018_671684_0012	007658-18	Resident Quality Inspection

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

SHELLEY MURPHY (684), STEPHANIE DONI (681), TIFFANY BOUCHER (543)

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): April 30-May 4, 2018, and May 7-11, 2018.

Additional Intakes inspected during this Resident Quality Inspection (RQI) included:

Follow up to Compliance Orders: one intake related to ensuring the home had a written description of the nutrition program which includes goals and objectives and relevant policies, procedures and protocols; one intake related to Abuse policy evaluation; one intake related to .ensuring that the home immediately reports any suspected abuse to the Director, and; one intake related to bed rail use.

-One critical incident, related to missing resident.

-One critical incident , related to staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Interim Director of Care, Director of Care(DOC), Former Director of Care, Kitchen/Maintenance Manager, Activity Director, Resident-Assessment-Instrument (RAI) Coordinator, Registered Dietitian (RD), Pharmacist, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Cook, Dietary Aide, family members, and residents.

Inspector also conducted daily tours of the resident care areas, reviewed relevant resident care records, home investigation notes, home policies, procedures, programs, personnel files, observed resident rooms, resident common areas, and the delivery of resident care and services, including resident-staff interactions.

The following Inspection Protocols were used during this inspection:

Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

- **13 WN(s)**
- **8 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #002	2018_638609_0003	684
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #001	2018_638609_0003	543
O.Reg 79/10 s. 30. (1)	CO #003	2018_638609_0003	681
O.Reg 79/10 s. 99.	CO #004	2018_638609_0003	543

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 the care set out in the plan of care was provided to the resident as specified in the plan.

During an interview with Registered Nurse (RN) #110 and Inspector #684, RN #110 indicated that resident #003 had fallen on a specified day in 2018.

Inspector #543 reviewed resident #003's most recent care plan, specifically related to falls. The resident's care plan indicated the following related to limited physical mobility, the resident required a specified mobility aid for ambulating, and an ADL focus in the care plan indicated that the resident required specific interventions. Resident #003's care plan identified under the falls focus, that the resident had an impairment. There were a number of specific interventions to be utilized for falls noted in care plan.

Inspector #543 observed resident #003 on four separate days in 2018, and identified that the resident did not have one intervention in place.

On two different days in 2018, while speaking with Inspector #543, resident #003 verified that they did not have a specified intervention in place for falls prevention.

Personal Support Worker (PSW) #104 verified that one specified interventions was unavailable for resident #003, and that resident #003 required another intervention, but that was not in place.

During an interview with Inspector #543, Registered Practical Nurse (RPN) #122 verified

that resident #003 did require a specified piece of equipment and that the care plan identified the need for a second piece of equipment but that this specific piece of equipment was not available. [s. 6. (7)]

2. Resident #001 was identified as having altered skin integrity to a specified area on their body and a second area of altered skin integrity to another area on their body, this was identified through a record review and a staff interview.

Inspector #681 reviewed resident #001's most recent plan of care, which directed staff to to perform a specific task.

On two separate days in 2018, Inspector #681 observed resident#001 and identified that, a specific intervention for resident #001 was not followed during these observations.

During an interview with PSW #119, they stated that they were assisting resident #001 and verified that the intervention was not followed for resident #001, and that it was not utilized because the PSW was "short on time".

During an interview with RN #106, they informed inspector #681 of the specified intervention that was to be utilized for resident #001 and that this was indicated in resident #001's plan of care. RN #106 stated that resident #001 had previous altered skin integrity issues caused from not utilizing the intervention appropriately.

During an interview with Director of Care (DOC) #124, they verified that resident #001 should not have had the intervention utilized incorrectly.

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs changed or care set out in the plan was no longer necessary.

Inspector #684 reviewed resident #012's current care plan related to continence care as a result of a Minimum Data Set (MDS) assessment indicating a change in their continence care needs. Resident #012's care plan, stated specific interventions on how care was to be provided.

Inspector #684 reviewed MDS admission to 90 day assessment which indicated resident #012 required specific interventions for continence care, subsequently, the quarterly assessment indicated resident #012's interventions had changed.

Inspector #684 interviewed PSW #109 and asked where they would find information on how care was to be provided to resident #012. PSW #109 indicated they would look in Point of Care (POC), the kardex and care plan. PSW #109 indicated that resident #012 required certain interventions related to their continence care needs, but there were days where resident #012 required more interventions.

Inspector #684 interviewed resident #012, they stated that sometimes they required interventions from staff.

During an interview with RPN/Resident-Assessment-Instrument (RAI) Coordinator #107 they stated to Inspector #684 that they would update a resident care plan, if there were any changes or changes with the resident's health status. RPN/RAI Coordinator #107 confirmed that the care plan needed to be updated as resident #012 had a change.

Inspector #684 interviewed Administrator #101 about where staff would go to find out what type of care a resident required, they stated the kardex on POC, printed care plans and they could ask the nurse. They also stated that care plans were to be updated whenever there was a change in resident's health status. [s. 6. (10) (b)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that they reported to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

A critical incident (CI) report was reported to the Director on a specified day in 2018, related to alleged staff to resident abuse. This incident took place on a specific day in 2018, but was not reported to management of the home until two days later. According the CI report, PSW #120 provided inappropriate care and was physically abusive towards resident #007.

Inspector #543 reviewed resident #007's progress notes for documentation related to the alleged incident that had occurred on a day in 2018. A late entry dated two days later, indicated the day before that resident #007 had notified RN #121 of the alleged incident of abuse that had occurred.

Inspector #543 reviewed the CI report, and identified that the home had not updated the report to indicate the results of the alleged staff to resident abuse investigation.

Inspector #543 interviewed the Administrator who verified that the CI report was not updated indicating the results of the investigation. [s. 23. (2)]

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 they report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b), to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with a change of 7.5 per cent of body weight, or more, over three months were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.

Resident #003 was identified as having a change in weight since their admission through a record review completed by Inspector #684.

Inspector #681 reviewed resident #003's weight history and identified that resident #003 experienced a change in weight, over a five month period. Inspector #681 reviewed resident #003's electronic medical record and was unable to locate documentation which indicated that resident #003's weight change had been assessed.

During an interview with Inspector #681, the RAI Coordinator indicated that they submitted a dietary referral for resident #003, related to the weight change that resident #003 had experienced. The RAI Coordinator stated that, despite the dietary referral being submitted, resident #003 was not assessed by Registered Dietitian (RD) #115 and the referral was not completed.

Inspector #681 reviewed the home's policy titled "Monthly Resident Weight Monitoring", last revised April 26, 2018, which indicated that significant weight changes (5 per cent change in one month, 7.5 per cent change in three months, and 10 per cent change in six months) were to be reviewed and prioritized by the clinical dietitian for follow-up. The Monthly Resident Weight Monitoring policy also indicated that the clinical dietitian was to make recommendations for significant weight changes which may include: diet changes, nutritional intervention program, in-between meal nourishments, therapeutic nutritional supplementation, weekly weight monitoring, or food and fluid intake monitoring.

During an interview with RD #114, they stated that they just started providing dietetic services to the home on a specified day in 2018. RD #114 stated that in a specified period of time resident #003 experienced a weight change of a certain percentage of their body weight, and that resident #003 had not had their weight change assessed by the home's previous RD and that an assessment should have been completed. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 ensure that residents with a change of 7.5 per cent of body weight, or more, over three months were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a registered dietitian who was a member of the staff of the home was on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

A home with a licensed bed capacity of 59 beds requires a registered dietitian to be onsite for a minimum of 29.5 hours per month.

Resident #003 was identified as having a significant weight change since admission and resident #001 was identified as having impaired skin integrity to specific areas of their body through a record review.

Inspector #681 reviewed resident #003's electronic medical record, which indicated that a dietary referral was submitted by the RAI Coordinator on a date in 2018, related to resident #003's weight change. However, Inspector #681 was unable to locate documentation to indicate that resident #003's weight change had been assessed by the home's RD.

Inspector #681 also reviewed resident #001's electronic medical record, which indicated that a dietary referral was submitted by RN #118 on a date in 2018, related to the resident's altered skin integrity. However, Inspector #681 was unable to locate documentation to indicate that resident #001 had been assessed by the home's RD prior to April 26, 2018.

During an interview with Inspector #681, RD #114 stated that they just started working at the home on a date in 2018, and prior to this, RD #115 was responsible for providing dietetic services to the home.

Inspector #681 requested that the home's RAI Coordinator provide a list of all the dietary referrals that were submitted during the period of three months in 2018, as well as, all the progress notes that were entered by RD #115 during this time period. A total of 13 dietary referrals were submitted for one month in 2018, 15 dietary referrals were submitted the next month 2018, and eight dietary referrals were submitted the following month in 2018. However, only six nutrition assessment notes were entered by RD #115 in this time frame in 2018.

During an interview with the Dietary Manager, they stated that they were only aware of one afternoon where RD #115 was onsite at the home in a three month period in 2018. The Dietary Manager stated that RD #115 did not provide them with a schedule of when they would be in the home, nor was there any communication between the Dietary Manager and RD #115.

During an interview with the Administrator, they stated that RD #115 had a contract for 35 hours per month and that they were expected to be onsite one day per week. The Administrator stated that they became aware that RD #115 was not completing required assessments on a specified day in 2018, when RN #123 sent the Administrator an email to advise them of missing assessments and documentation that should have been completed by RD #115. The Administrator stated that it was at this time that they were made aware that RD #115 had not been onsite at the home since a earlier specified date in 2018. The Administrator also stated that they spoke with RD #115 on a date in 2018, and that RD #115 acknowledged that they were not putting forth the required hours because of competing work commitments. RD #115 subsequently resigned on a date in 2018. [s. 74. (2)]

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 a registered dietitian who was a member of the staff of the home was on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents' Council in developing and carrying out the survey, and in acting on its results.

Inspector #681 reviewed the Long Term Care Home (LTCH) Licensee Confirmation Checklist related to Quality Improvement and Required Programs, which indicated the licensee did not seek the advice of Residents' Council in developing and carrying out the annual satisfaction survey, and in acting on its results.

During an interview with resident #018, they stated that they regularly attended Residents' Council meetings; however, they did not recall reviewing the satisfaction survey or discussing the results of the completed survey.

During an interview with the Activity Director #111, they stated that they were responsible for assisting with Residents' Council meetings. The Activity Director stated that the annual satisfaction survey had not been discussed at a Residents' Council meeting, nor had the results been shared with members of Residents' Council.

During an interview with the Administrator, they stated that the home's satisfaction survey was last completed in May 2017. The Administrator reported that the survey was not developed in consultation with Residents' Council and the results of the survey were not discussed with Residents' Council. [s. 85. (3)]

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 licensee seeks the advice of the Residents' Council in developing and carrying out the survey, and in acting on its results, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s.101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12).

Findings/Faits saillants :

1. The licensee has failed to ensure that they complied with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

The Licensee was to be compliant with order #002 from Inspection #2018_638909_003 dated Feb 23, 2018, which had a compliance date of April 6, 2018.

The licensee was ordered to ensure that, a)"Where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and (c) other safety issues related to the use of bed rails are addressed, including height and latch reliability.
b)Ensure that all staff involved in the assessment of bed rails are trained and familiar with the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" and "Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Health Care Facilities" guidance documents.
c)Perform a review of all residents and their bed systems to ensure that the plans of care accurately reflect the use of bed rails. The home will maintain a record of the required review.
d) Implement a process to ensure that registered staff notify the maintenance staff to assess the resident's bed system prior to the use of bed rails. The process will require the home to track which residents and bed systems need assessment and reassessment.
e) Ensure that registered staff assess and document the assessment of the resident prior to the use of bed rails."

While the licensee complied with sections "a", "c", and "e", non-compliance continued to

be identified with section "b" and "d", where the licensee was ordered to train staff on bed entrapment and bed rail assessments and implementation and implement a process to ensure registered staff notify the maintenance staff to assess the resident's bed system prior to the use of bed rails.

Inspector #684 interviewed RPN #107 to identify if they had been trained on bed rail assessments, they indicated that this assessment was fairly new and they had not been trained on this. Inspector #684 also asked RPN #107 if there was a process to notify maintenance of a bed rail that needed to be assessed. RPN #107 indicated that they were not aware of such a process.

Maintenance manager #102 was unable to locate documentation to show that staff education was completed for the assessment of bed rails. They then indicated that there was no formal process in place to ensure that registered staff notified the maintenance staff to assess the resident's bed system prior to the use of bed rails. They also stated, so far, they had created a Bed Rail Requisition form but this had not been put into place.

Maintenance manager #102 confirmed that the training was not completed, and that there had been no process put into place to notify maintenance staff to assess a resident's bed system prior to the use of bed rails.

Inspector #684 interviewed Administrator #101 regarding training not being completed, as well as the process to inform maintenance that bed rails need assessment; Administrator #101 confirmed that both of these areas had not been completed. [s. 101. (3)]

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 they comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Inspector #543 was reviewing the medication incident reports for the home, and identified that there had been no quarterly meetings conducted with an interdisciplinary team to evaluate the effectiveness of the medication management system.

Inspector #543 interviewed DOC #124 who verified that the home had not conducted quarterly meetings related to the medication management system.

Inspector #543 interviewed the Clinical Consultant Pharmacist related to the quarterly meetings for the medication management system in the home, they verified that there had been no quarterly meetings held since 2017. [s. 115. (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 an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, to be implemented voluntarily.

WN #8: 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. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that:
(a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions,
(b) any changes and improvements identified in the review were implemented, and
(c) a written record was kept of everything provided for in clause (a) and (b).

Inspector #543 was reviewing the medication incident reports from November 2017, to January 2018, for the home, and identified that there had been no quarterly review undertaken of all medication incidents and adverse drug reactions that occurred in the home.

Inspector #543 interviewed DOC #124 who verified that the home had not conducted quarterly meetings related to medication incidents.

Inspector #543 interviewed the Clinical Consultant Pharmacist who verified that there had been no quarterly reviews since 2017. [s. 135. (3)]

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:
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions
(b) any changes and improvements identified in the review are implemented, and
(c) a written record is kept of everything provided for in clause (a) and (b), to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; O. Reg. 79/10, s. 229 (2).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's "Infection Prevention and Control" program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Inspector #543 reviewed the home's "Infection Prevention and Control" program and identified that the program was last reviewed in March 2015, and the latest revision recorded was in March 2011. It was identified that various parts of the IPAC program were reviewed on different dates; however, the most recent review of the program was completed in March 2015.

On a specified day in 2018, Inspector #543 interviewed the Administrator, who verified that the home's "Infection Prevention and Control" program had not been evaluated or updated in the last year. The Administrator indicated that if there was no evaluation record in the Infection Prevention and Control policy binder, then there was no evaluation completed in the last year. [s. 229. (2) (b)]

2. The licensee has failed to ensure that the following immunization and screening measures were in place: residents must be offered immunizations against

pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Inspector #543 reviewed the LTCH Licensee Confirmation Checklist-Infection Prevention and Control completed by the Administrator. The Inspector identified that the Administrator indicated on the checklist that residents were not offered immunization against pneumococcus, tetanus and diphteria in accordance with the publicly funded immunization schedules posted on the Ministry website.

In an interview with Inspector #543, the Administrator verified that the home did not offer immunization against pneumococcus, tetanus and diphtheria. [s. 229. (10) 3.]

3. The licensee has failed to ensure that the following immunization and screening measures were in place: staff were screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Inspector #543 reviewed the LTCH Licensee Confirmation Checklist-Infection Prevention and Control completed by the Administrator. The Inspector identified that the Administrator indicated on the checklist that staff were not screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

In an interview with Inspector #543, the Administrator verified that staff were not screened for tuberculosis or any other infectious diseases. [s. 229. (10) 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 ensure that the home's "Infection Prevention and Control" program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, that the following immunization and screening measures were in place: residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website, and to ensure that the following immunization and screening measures were in place: staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident had occurred or may occur immediately report the suspicion and the information upon which it is based to the Director.

A CI report was reported to the Director on a specified day in 2018, related to alleged staff to resident abuse which had occurred two days earlier, this was reported to management of the home on the day before the report was submitted to the Director. According the CI report, PSW #120 provided inappropriate care and was abusive towards resident #007.

Inspector #543 reviewed resident #007's health care record, and identified a progress note describing that at a specific time on one day, resident #007 had informed RN #121 of an incident of alleged staff to resident abuse. The progress note indicated the specifics of what occurred between PSW #120 and resident #007.

Inspector #543 interviewed the Administrator who verified that the incident had been reported late. They indicated that it was the responsibility of staff to immediately report alleged abuse to the Director.

This non-compliance will serve to support a previous compliance order, which had a compliance due date after the date in which this CI was submitted.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team providing a resident's care was held annually to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; the resident, the resident substitute decision maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and a record was kept of the date, the participants and the results of the conferences.

During an interview with inspector #684, resident #010's family member indicated that they had not been invited to the annual care conference for resident #010.

Inspector #684 spoke to RPN/RAI coordinator #107, regarding when they invite a family to the annual care conference if this was noted somewhere. RPN/RAI coordinator #107 stated they make a note in the progress notes either under Interdisciplinary Team Conference Note or Resident/Family Meeting.

Inspector #684 reviewed resident #010 progress notes for documentation on the family invite to the annual care conference. Under the Resident/Family Meeting heading no notes were found and under the Interdisciplinary Team Conference Note, the last note was from four years earlier.

Inspector #684 asked RPN/RAI coordinator #107, to show inspector #684 the documentation for resident #010 that would indicate the family had been invited to the resident's annual care conference. RPN/RAI coordinator #107, was unable to locate documentation from the last year.

Inspector #684 reviewed the policy titled Admission and Annual Care Conference from section 4.0 of the resident services manual, subsection 4.7, dated August 2013. Statement of Purpose for this policy indicates, Annual care conferences are also held with residents and families to review and update the plan of care.

Inspector #684 interviewed Administrator #101 regarding care conferences, to which they stated "I do know we are behind with them and now we are working on them". [s. 27. (1)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a dining and snack service that included course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

Inspector #681 observed the lunch meal in one Dining Room on two different days in 2018. During both of these meal observations, Inspector #681 observed that all the residents in the specified Dining Room were served the soup and the main meal at the same time.

During an interview with resident #018, they stated that they eat their meals in the specified Dining Room and that the soup was always served with the main meal at lunch. Resident #018 stated that sometimes their main meal gets cool by the time they get to eat it because they "want to eat the soup while it is hot".

During an interview with PSW #112, they stated that, at lunch, staff serve the soup and the main meal at the same time. PSW #112 stated that following the Resident Quality Inspection last year, staff were advised to serve the soup first, followed by the main course and that this change was implemented for "a while". However, the home had since returned to serving the soup and main meal together at lunch in the specified Dining Room.

Inspector #681 reviewed the home's policy titled "Meal Service Delivery", last revised April 19, 2018, which indicated that meals were served one course at a time, unless individual residents request otherwise.

During an interview with the Dietary Manager, they acknowledged that the lunch meals were not served course by course in the specified Dining Room. The Dietary Manager stated that serving the lunch meal course by course would take away from the physical and verbal assistance that staff were providing to the residents in the Dining Room because staff would have to get up from assisting residents to remove the dirty soup bowls and serve the main meals. The Dietary Manager also stated that not serving the lunch meal course by course helped to maintain a calm environment in the specified Dining Room. The Dietary Manager reported that they were not aware of any documentation to support that serving the soup and main meal together at lunch was based on the residents' assessed needs or resident request. [s. 73. (1) 8.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to ensure the security of the drug supply, including the following: 2. Access to these areas shall be restricted to, persons who may dispense, prescribe or administer drugs in the home.

On a day in 2018, Inspector #681 observed one resident in the medication room, and two other residents standing in the doorway.

On another day in 2018, Inspector #543 was in the medication room conducting an interview with RPN #122 and the Administrator. During that time, several residents entered the medication room.

Inspector #684 interviewed RPN #108 who verified that the PSWs did have access to the medication room, and that shift report was conducted in the medication room.

Inspector #681 observed resident #003 having a diagnostic test performed in the medication room.

Inspector #684 interviewed PSW #105 who verified that they received shift report in the medication room.

In an interview with the Administrator, they verified that PSWs did have access to the medication room. [s. 130. 2.]

Issued on this 24th day of May, 2018

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

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) :	SHELLEY MURPHY (684), STEPHANIE DONI (681), TIFFANY BOUCHER (543)
Inspection No. / No de l'inspection :	2018_671684_0012
Log No. / No de registre :	007658-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 22, 2018
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 :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be in compliance with s. 6 (7) of the LTCHA. Specifically the licensee must;

-a) Ensure that resident #003's care related to falls and required equipment for falls prevention be available at all times, and any other residents requiring care and/or equipment related to falls be provided as specified in the plan, and
-b) Ensure that resident #001 and any other resident with wounds be provided care as specified in the plan of care in the management of their wounds.

Grounds / Motifs :

1. 2. Resident #001 was identified as having altered skin integrity to a specified area on their body and a second area of altered skin integrity to another area on their body, this was identified through a record review and a staff interview.

Inspector #681 reviewed resident #001's most recent plan of care, which directed staff to to perform a specific task.

On two separate days in 2018, Inspector #681 observed resident#001 and identified that, a specific intervention for resident #001 was not followed during these observations.

During an interview with PSW #119, they stated that they were assisting resident #001 and verified that the intervention was not followed for resident #001, and that it was not utilized because the PSW was "short on time".

During an interview with RN #106, they informed inspector #681 of the specified intervention that was to be utilized for resident #001 and that this was indicated

in resident #001's plan of care. RN #106 stated that resident #001 had previous altered skin integrity issues caused from not utilizing the intervention appropriately.

During an interview with Director of Care (DOC) #124, they verified that resident #001 should not have had the intervention utilized incorrectly.
(681)

2. 1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

During an interview with Registered Nurse (RN) #110 and Inspector #684, RN #110 indicated that resident #003 had fallen on a specified day in 2018.

Inspector #543 reviewed resident #003's most recent care plan, specifically related to falls. The resident's care plan indicated the following related to limited physical mobility, the resident required a specified mobility aid for ambulating, and an ADL focus in the care plan indicated that the resident required specific interventions. Resident #003's care plan identified under the falls focus, that the resident had an impairment. There were a number of specific interventions to be utilized for falls noted in care plan.

Inspector #543 observed resident #003 on four separate days in 2018, and identified that the resident did not have one intervention in place.

On two different days in 2018, while speaking with Inspector #543, resident #003 verified that they did not have a specified intervention in place for falls prevention.

Personal Support Worker (PSW) #104 verified that one specified interventions was unavailable for resident #003, and that resident #003 required another intervention, but that was not in place.

During an interview with Inspector #543, Registered Practical Nurse (RPN) #122 verified that resident #003 did require a specified piece of equipment and that the care plan identified the need for a second piece of equipment but that this specific piece of equipment was not available. [s. 6. (7)]

The severity of this issue was determined to be a level three, as there was

actual harm/risk to residents in the home. The scope of the issues was a level one, isolated. The home had a level three compliance history, as there was one or more related non-compliance in the last 36 months. (543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 22, 2018

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 22nd day of May, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Shelley Murphy

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