Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
December 21,22,23, 2010	2010_158_1856_21Dec085358	Follow up S- 00781

Licensee/Titulaire
Wikwemikong Nursing Home Limited, 2281 Wikwemikong Way, P.O. Box 114, Wikwemikong ON P0P 2J0
Fax- 705 859-2245

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

Wikwemikong Nursing Home Limited, 2281 Wikwemikong Way, P.O. Box 114, Wikwemikong ON P0P 2J0
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Name of Inspector(s)/Nom de l'inspecteur(s)
Kelly-Jean Schienbein # 158, Monique Berger # 151, Anne Costelo, # 177

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a follow up inspection.

During the course of the inspection, the inspector spoke with: Registered Nursing staff, Personal Support Workers (PSW), the Dietitian, the Maintenance manager, and residents

During the course of the inspection, the inspector: conducted a walk through of all resident home areas and various common areas, observed residents, observed staff practices and interactions with the resident, reviewed the health care record of residents.

The following Inspection Protocols were used during this inspection:

- Skin and Wound
- Falls Prevention
- Critical Incident
- Personal Support Care

Findings of Non-Compliance were found during this inspection. The following action was taken:

WN 18
VPC 14

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN # 1: The Licensee has failed to comply with LTCHA , S.O. 2007, c,8, s. 8 (3)
Every licensee of a long-term care home shall ensure that a least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times

Findings:
A review of the Registered staff work schedule was done by inspector 151 over the period of Nov. 28/10 to Dec.11/10 show the following:
7.14% shortfall on day shift
78.6% shortfall on evening shift
57.1% shortfall on night shift
The home did not ensure that at least one Registered Nurse was on duty or present in the home at all times.

Inspector ID #:	158

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 at least one Registered Nurse who both an employee of the licensee and a member of the regular nursing staff is on duty and present in the home at all times, to be implemented voluntarily.

WN # 2: The Licensee has failed to comply with O Reg 79/10, s. 229. (4)
The licensee shall ensure that all staff participate in the implementation of the infection control program

Findings:
- Poor hand washing practices were observed by inspector 151 and 158 on Dec. 21/10 and Dec. 22/10; i.e. Staff not washing their hands between care, treatment and medication administration provided to different residents

Inspector ID #:	151, 158

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 ensuring that all staff participate in the infection control program, to be implemented voluntarily.

WN # 3: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 8, (4)
During the hours that an Administrator or Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home

Findings:

1. The combined Administrator/DOC (Adm/DOC) position of a home with 59 licensed beds should be 40 hours a week or 5 days per week or full time. (Administrator hours =16 / DOC hours = 24 hours)
2. Review of the Adm/DOC schedule for Nov. 28 to Dec. 11/2010 by inspector 151 on Dec. 22/10 shows that the Adm/DOC worked 32 hours per week in this capacity - a shortfall of 8 hours per week or 20%.
3. Review of the RN staffing schedule for Nov. 28 to Dec. 11/2010 by inspector 151 on Dec. 22/10 shows that Adm/DOC worked as the Registered Nurse on Doctor Day for 8 hours per week or 20%.
4. The Adm/DOC was considered to be a registered nurse on duty and present in the home during the hours that she was to regularly work in the capacity of the home's Adm/DOC position on site at the home.

Inspector ID #:	151

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 with the Administrator/DOC hours, to be implemented voluntarily.

WN # 4: The Licensee has failed to comply with, LTCHA 2007, S.O. 2007, c.8, s.6(10)(b)
The licensee shall ensure that the resident is assessed and the plan of care reviewed and revised at least every six months and at any time when the resident's care needs change or care set out in the plan of care is no longer necessary.

Findings:

1. A resident was diagnosed with an urinary tract infection on December 12, 2010.
2. The post treatment culture/sensitivity urine sample was not collected as ordered.
3. Inspector 158 interviewed the Adm/DOC on December 22, 2010 who identified that doctor orders for urine tests etc are transcribed in the Registered staff daybook.
4. The Registered staff daybook was reviewed by inspector 158 on December 22, 2010. There was no entry for this resident's urine collection written.
5. The Adm/DOC confirmed that this resident's urine was not collected when interviewed on Dec. 22/10.
6. A post fall assessment for this resident was not completed when they returned from hospital post fracture..
7. This resident was not reassessed when their care needs changed.

Inspector ID #:	158

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 ensuring that all residents are reassessed and their care plans are reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN # 5: The Licensee has failed to comply with LTCHA, S.O. 2007, c 8, s. 5
Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

Findings:

1. Inspector 151 observed that 3 of 4 fire exits were blocked with furniture and garbage cans on Dec. 21/10.
2. The exit by the nursing office was noted by Inspector 151 and Inspector 177 to be blocked by lounge chairs on Dec 21/10.
3. Inspector 158 observed on Dec.22/10 that a housekeeping cart was blocking the resident's bathroom entrance.
4. Inspector 158 observed staff to not respond to resident call bells on Dec. 22/10 at 2:30 pm while receiving a mini in-service on point of care monitors on the unit
5. The home did not ensure that the home is a safe environment for its residents.

Inspector ID #:	151, 158, 177

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 ensuring that exits are not blocked, and resident's call bells are responded to, to be implemented voluntarily.

WN # 6: The Licensee has failed to comply with O Reg 79/10, s. 89 (1) (c)
Every licensee of a long-term care home shall ensure that linen, face cloths, and bath towels are maintained in a good state of repair

Findings:

1. Thread bare and ragged edged face cloths were found at resident's bedsides in Rooms 2, 4, 9 on Dec. 22/10 by inspector 158.
2. Several thread bare, ragged edged face cloths and hand towels were found and removed from the men's side linen room by inspector 158 on Dec. 22/10.
3. The home did not ensure that face cloths and bath towels are maintained in good condition.

Inspector ID #:	158

WN # 7: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c. 8, s. 3 (1) 8
Every resident has the right to be afforded privacy in treatment and in caring for his personal needs

Findings:

1. Inspector 158 observed a resident sitting in their wheel chairs in the hallway outside the nursing station on Dec.22/10 at 1310h when two PSW's positioned the resident forward and lifted the resident's shirt to expose the back so that the doctor, a medical student, and the DOC could see the reddened areas on the upper and lower back. An activity aide was also able to see the resident's back.
2. The resident's privacy was not provided.

Inspector ID #:	158

WN # 8: The Licensee has failed to comply with O Reg 79/10, s. 114 (2)
The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage administration and destruction and disposal of all drugs used in the home.

Findings:

1. Inspector 158 reviewed the home's pharmacy and nursing policy and procedure manual on Dec. 22/10.
2. A protocol regarding transcribing physician's orders was not found.
3. A narcotic control administration and record management protocol was not found.
4. An medication allergy alert protocol was not found.
5. Written policies and protocols were not developed for the home's medication management system.

Inspector ID #:	158

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 with the development of medication management policies and procedures, to be implemented voluntarily.

WN # 9: The Licensee has failed to comply with The Licensee has failed to comply with o Reg 79/10, s. 114 (3) a
The written policies and protocols must be developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices

Findings:

1. A resident's health record was reviewed by inspector 158 on Dec.22/10 and identified that the resident was admitted into the hospital for six days.
2. The resident's Medication Administration Record was reviewed by inspector 158 and showed that the evening medication was given by the RPN on the day the resident returned from the hospital.
3. The resident's doctor orders were reviewed by inspector 158. There was no doctor orders found written or telephoned ordered on the day the resident was readmitted from the hospital into the home.
4. The physician wrote in the physician's record that the medications that were given to the resident on the day she returned to the home had not been ordered.
5. The home's policy for admission / readmission reviewed by inspector 158 identified under # 12 that "the physician's orders are to be obtained immediately".
6. The home's policies were not implemented.

Inspector ID #:	158.

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 ensuring that policy for obtaining medication orders from the physician be implemented by staff when residents return from hospital, to be implemented voluntarily.

WN # 10: The Licensee has failed to comply with O Reg 79/10, s. 114 (1)
Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents

Findings:

1. Inspector 158 observed a RN alone and in the process of counting the narcotics for the west wing (men's side) on Dec 22/10 at 14:45. The RN stated to inspector 158 when questioned on Dec.22/10 that staff do not count the narcotics with the oncoming shift or "double sign". Inspector 158 observed a RPN also count the narcotics alone at 14:50 on Dec 22/10. Inspector 158 noted on Dec.22/10 that in the home's document titled "Nursing Routines – day and evening shift", that narcotics are to be counted and doubled signed with outgoing staff.
2. A resident's health care record was reviewed by inspector 158 on Dec. 22/11. The pharmacy care plan identified "Allergy" to a specific medication. The Nov/10 and Dec/10 MAR identified this same medication as an allergy. However, this medication was administered to the resident until it was discontinued.
3. Management of a safe medication system was not provided.

Inspector ID #:	158

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 safe medication system related to allergy alerts and narcotic control management is developed, to be implemented voluntarily.

WN # 11: The Licensee has failed to comply with O Reg 79/10, s.17 (1) (a)
Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication system that can be easily seen, accessed and used by residents, staff or visitors at all times.

Findings:

1. Call bells were observed by inspector 158 to be located behind the head of resident beds and not within reach of 5 residents who were seated in their rooms in wheelchairs beside their respective beds on Dec.22/10.
2. The home did not ensure that the resident-staff communication system can be easily seen, accessed and used by residents at all times.

Inspector ID #:	158

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 ensuring that the resident-staff communication system is easily seen, and accessible by all residents at all times, to be implemented voluntarily.

WN # 12: The Licensee has failed to comply with O Reg 79/10, s. 93
Every licensee of a long-term care home shall ensure that there are in place written policies respecting pets in the home.

Findings:

1. A cat was observed to be in the home Dec 22/10 by inspector 158. The Administrator/DOC commented to inspector 158 on Dec.22/10 that the cat is not owned by the home but is allowed to stay when it returns from its outings. The immunization status of the cat was not known by the Administrator/DOC.
2. An employee brought in three puppies and the mother dog to visit with the residents on Dec.22/10. A quiet growl was heard from the mother dog. The employee stated that the dog may bite.
3. The DOC confirmed that there is no policy related to pets residing in or visiting the home.

Inspector ID #:	158

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 ensuring that a policy regarding pets in the home is developed and put in place, to be implemented voluntarily.

WN # 13: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c8, s. 6 (1) (c)
Every licensee of a long-term care home shall ensure there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

Findings:

1. Inspector 151 reviewed a resident's care plan on Dec. 22/10 and the dietary interventions described by the Dietician on December 21, 2010 to inspector 151 were not found in the resident's plan of care.
2. It was also noted by inspector 151 that interventions related to a resident's seizure disorder were not found in their plan of care.
3. Inspector 158 spoke with the physiotherapy aide on Dec 22/10 who stated that a resident receives daily specific leg and arm strengthening exercises and is on a walking program three times a week. These interventions were not found in their care plan.
4. A resident's care plan which was reviewed by inspector 158 on December 22/10 identified a wound care treatment. However, the frequency of the wound care treatment was not identified.
5. A resident's care plan which was reviewed by inspector 158 on December 22/10 identified "magnetic monitoring in order to decrease falls and provide safety". The type of monitor and when to use the monitor was not identified.
6. A resident's care plan which was reviewed by inspector 158 on December 22/10 identified the use of one half rail, two rails and full rails on all open sides when in bed. Direction regarding side rail use is unclear.

Inspector ID #:	151, 158

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 ensuring that resident's written care plans set out clear direction to staff, to be implemented voluntarily.

WN # 14: The Licensee has failed to comply with O Reg 79/10, s. 50 (2) (b) (iii)
Every licensee of a long-term care home shall ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears, or wounds is assessed by a registered dietician who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration be implemented.

Findings:

1. A resident was assessed by the registered dietician; however, the plan of care did not include the strategies described by the Dietician in the interview held Dec. 21/10 at 15:20 with inspector 151.

Inspector ID #:	151,158

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 ensuring that nutrition and hydration changes are made to all residents' plan of care, to be implemented voluntarily.

WN # 15: The Licensee has failed to comply with O Reg 79/10 s. 50 (2) (c)
Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote

Findings:

1. Inspector 151 observed a resident's wound dressing change on Dec.21/10. It was noted that the prescribed medication for the wound treatment was not used and that staff had to adapt other dressing supplies to compensate for the lack of packing materials. The RN stated there hadn't been any of this medication available for 3 days.
2. On December 22, 2010, the Administrator/Director of Care stated that the product was available however, the inspector noted that it was not located with the other wound care supplies in the medication room.

Inspector ID #:	151

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 ensuring that all supplies that are necessary for wound care dressings are readily available, to be implemented voluntarily.

WN # 16: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 6 (8)
The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

Findings:

1. Inspector 151 and Inspector 158 observed on Dec. 22/10 at 11:00 that all plans of care were stored in a locked room across from the nursing station. Only one PSW had a key to this room.
2. The home did not ensure that the staff and others who provide direct care to a resident have convenient and immediate access to the resident's plan of care.

Inspector ID #:	151,158

WN # 17: The Licensee has failed to comply with 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 as specified in the plan.

Findings:

1. Inspector 158 reviewed a resident's plan of care on Dec. 22/10. The resident's was identified at high risk for falls. As part of the plan of care, the call bell/alarm was to be placed within the resident's reach at all times. Inspector 158 observed the resident on Dec 22/10 sitting in the wheel chair by the end of the bed. The call bell was up around the head of the bed and under the pillow. It was not within the resident's reach.
2. Inspector 158 observed on December 22/10, a resident being transferred onto the toilet then left unattended. The resident was observed by inspector 158 to be shaky while seated on the toilet. Inspector 158 reviewed the resident's plan of care. The plan of care identified that the resident is unable to maintain balance in a sitting position without physical assistance.
3. The care set out in the plan of care was not provided to residents.

Inspector ID #:	158

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 ensuring that residents receive the care set out in their care plan, to be implemented voluntarily.

WN # 18: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 3 (1) 1
Every resident has the right to be treated with respected and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Findings:

1. Inspector 151 observed a staff person infantilizing a resident by saying "that's my boy, that's a good boy.....say please" on Dec. 22/10.
2. A resident's dignity was not respected.

Inspector ID #:	151

Signature of Licensee or Representative of Licensee	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la

Signature du Titulaire du représentant désigné	responsabilisation et de la performance du système de santé.
Title: Date:	Date of Report: (if different from date(s) of inspection).