Ontario

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
Direction de l'amélioration de la performance et de la conformité

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

	☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public		
Name of Inspector:	Melissa Chisholm	**Inspector ID #**	188
Log #:	S-001091-11		
Inspection Report #:	2011_188_1856_11Mar105111		
Type of Inspection:	Follow-up		
Date of Inspection:	March 14, 15 & 16, 2011		
Licensee:	Wikwemikong Nursing Home Limited, 2281 Wikwemikong Way, P.O. Box 114, Wikwemikong ON P0P 2J0, Fax-705-859-2245		
LTC Home:	Wikwemikong Nursing Home, 2281 Wikwemikong Way, P.O. Box 114, Wikwemikong ON P0P 2J0, Fax-705-859-2245		
Name of Administrator:	Elizabeth Cooper		

To Wikwemikong Nursing Home Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(a)
Pursuant to: 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 and response system that, can be easily seen, accessed and used by residents, staff and visitors at all times.			
Order: The license is required to ensure the resident-staff communication and response system is accessible to any resident in the home at all times when they are in bed.			
Grounds: 1. The licensee failed to ensure the home's resident-staff communication and response system was accessible to residents at all times based on observations by the inspector that five residents did not have access to their call bells while laying in bed.			
This order must be complied with by:	Immediately		

Order #:	002	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to:
O. Reg. 79/10, s.50(2)c Every licensee of a long-term care home shall ensure that, c) 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 healing.

Order:
The licensee is required to ensure a sufficient amount of appropriate dressing supplies are available in the home for the treatment of the identified resident's wounds, and the wounds of any other resident's in the home experiencing altered skin integrity.

Grounds:
1. The inspector observed the dressing change for a resident. The resident was ordered a certain wound treatment. The supplies required for this wound treatment were not available and the resident did not receive the ordered wound treatment. The licensee failed to ensure supplies for wound treatment were readily available at the home.

This order must be complied with by:	Immediately

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 service for the Licensee.

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

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
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 group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

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Ministry of Health and Long-Term Care
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Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Issued on this 24 day of June., 2011.	
Signature of Inspector:	
Name of Inspector:	Melissa Chisholm
Service Area Office:	Sudbury

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
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 603
Sudbury ON P3E 6A5

Telephone: 705-564-3130
Facsimile: 705-564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
Sudbury ON P3E 6A5

Téléphone: 705-564-3130
Télécopieur: 705-564-3133

☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Dates of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
March 14, 15 & 16, 2011	2011_188_1856_11Mar105111	Follow-up S-001091-11

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, 2281 Wikwemikong Way, P.O. Box 114, Wikwemikong ON P0P 2J0
Fax-705-859-2245

Name of Inspector/Nom de l'inspecteur
Melissa Chisholm #188

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, the Dietitian, the office clerk 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
Sufficient Staffing

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

7 WN
2 VPC
2 CO: CO # 001, 002

Corrected Non-Compliance is listed in the section titled Corrected Non-Compliance.

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, 2007, S.O. 2007, c.8, s.15(2) Every licensee of a long-term care home shall ensure that, the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Findings:

1. Inspection observed on March 14, 2011 a resident in their wheelchair. This wheelchair was observed by the inspector as being in a poor state of repair. The licensee has failed to ensure that this resident's wheelchair was maintained in a good state of repair.

2. Inspector observed on March 15, 2011 a resident sitting in their wheelchair. This wheelchair was observed as being in a poor state of repair. The licensee failed to ensure this resident's wheelchair was maintained in a good state of repair.

Inspector ID #:	188

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 in the home have their wheelchairs maintained in a good state of repair, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.3(1)8 Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted: #8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

Findings:

1. Inspector observed on March 15, 2011 a resident using the washroom. This resident was observed with pants down sitting on the toilet by the inspector who was walking down the hallway. Two staff members were in the hallway and took no action to provide the resident privacy. The licensee failed to ensure this resident received privacy while using the washroom on March 15, 2011.

2. Inspector observed on March 15, 2011 a personal support worker shaving a male resident at the nursing station with an electric razor. This was done in front of another staff member and several residents who were in the hallway and the common room beside the nursing station. The licensee has failed to provide this resident with privacy in caring for his personal needs.

3. Inspector observed on March 16, 2011 a resident using the washroom. This resident was observed with pants down sitting on the toilet by the inspector who was walking down the hallway. Two staff members were in the hallway and took no action to provide the resident privacy. The licensee failed to ensure this resident received privacy while using the washroom on March 16, 2011.	
Inspector ID #:	188
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 all residents in the home, have privacy while using the washroom, to be implemented voluntarily.	

WN #3: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(1)c Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, c) clear directions to staff and others who provide direct care to the resident.	
Findings: 1. The inspector reviewed the plan of care for a resident. The care plan indicates the resident receives one type of wound care treatment. The physician orders and treatment administration records indicate the resident receives a different wound care treatment. This is contradicting information for the staff and does not provide clear direction. The licensee failed to ensure the plan of care for this resident sets out clear direction with regards to wound care treatments.	
Inspector ID #:	188

WN #4: 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 to the resident as specified in the plan.	
Findings: 1. Inspector reviewed the treatment administration record (TAR) for a resident which identifies this resident receives a certain type of wound care treatment. This prescribed wound care treatment was not provided to the resident on March 15, 2011. The licensee failed to ensure the care was provided to this resident as specified in the plan. 2. Inspector reviewed the care plans of five different residents. Each care plan indicated the residents required their call bells within reach at all times. The inspector observed each of these residents without call bells within reach at different times throughout the inspection. The licensee failed to provide care to these residents as specified in their plans of care.	
Inspector ID #:	188

WN #5: 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 and response system that, can be easily seen, accessed and used by residents, staff and visitors at all times.	
Findings: 1. The licensee failed to ensure the home's resident-staff communication and response system was accessible to residents at all times based on observations by the inspector that five residents did not have access to their call bells while laying in bed.	
Inspector ID #:	188
Additional Required Actions: **CO #** - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.	

WN #6: The Licensee has failed to comply with O. Reg. 79/10, s.24(9)a The licensee shall ensure that the resident is reassessed and the care plan is reviewed and revised when, a) the resident's care needs change.

Findings:

1. Inspector reviewed the health care record and care plan for a resident. On March 7, 2011, the care needs for this resident changed. The care plan for this resident was reviewed on March 14, 2011 and did not reflect the change in care needs. The licensee failed to ensure the care plan was reviewed and revised when the care needs of this resident changed.

Inspector ID #:	188

WN #7: 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, c) 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 healing.

Findings:

1. The inspector observed the dressing change for a resident. The resident was ordered a certain wound treatment. The supplies required for this wound treatment were not available and the resident did not receive the ordered wound treatment. The licensee failed to ensure supplies for wound treatment were readily available at the home.

Inspector ID #:	188

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

CORRECTED NON-COMPLIANCE
Non-respects à Corrigé

REQUIREMENT EXIGENCE	TYPE OF ACTION/ORDER	ACTION/ CO-ORDER #	INSPECTION REPORT #	INSPECTOR ID #
LTCHA, 2007, S.O. 2007 c. 8, s.8(3)	WN, CO	001	2010_158_1856_21Dec085358	158

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). June 24/11