Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 14, 15, 16, 2011	2011_099188_0006	Follow up

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

MELISSA CHISHOLM (188)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Director of Care(DOC)/Administrator, Registered Nursing staff, personal support workers, office staff and residents.

During the course of the inspection, the inspector(s) Conducted a walk through of the home, reviewed newly admitted resident's health care records, reviewed various policies and procedures, reviewed registered staff schedules, observed medication storage areas, observed resident to staff interactions and observed residents personal belongings/rooms.

The following Inspection Protocols were used in part or in whole during this inspection:

Medication

Personal Support Services

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 122. Purchasing and handling of drugs

Specifically failed to comply with the following subsections:

s. 122. (1) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122 (1).

Findings/Faits sayants :

1. Inspector reviewed the medication cart and noted a bottle of eye drops with a pharmacy label that was not from the home's pharmacy provider. Inspector reviewed the drug storage area for a resident in the medication room and located two additional bottles of eye drops with a pharmacy label that was not from the home's pharmacy provider and a bottle of eye drops without any pharmacy label. The licensee failed to ensure that no drug is acquired, received or stored by or in the home unless the drug has been provided by the pharmacy service provider or the Government of Ontario.
2. Inspector noted that three cards of weekly dosed medication for a resident were being stored in the medication room. Inspector noted that these weekly dosed medication cards were dispensed by a pharmacy other than the home's pharmacy provider. The licensee failed to ensure that no drug is acquired, received or stored by or in the home unless the drug has been provided by the pharmacy service provider or the Government of Ontario.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits sayants :

1. Inspector reviewed the home's emergency stock box on June 15, 2011. Inspector noted the following expired medications in the emergency stock box.
- Vit K 1mg/0.5ml, 5 vials, expired 2010/12
- Vit K 10mg/1ml, 3 vials, expired 2011/04
- Epinephrine 1mg/1ml, 5 vials, expired 2011/03
- Xylocaine 10mg/1ml, 1 vial, expired 2011/04

The licensee failed to ensure medications are stored in a way that complied with manufacturer's intstructions for the storage of drugs.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following subsections:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:

1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks.

2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks.

3. The type and level of assistance required relating to activities of daily living.

4. Customary routines and comfort requirements.

5. Drugs and treatments required.

6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions.

7. Skin condition, including interventions.

8. Diet orders, including food texture, fluid consistencies and food restrictions. O. Reg. 79/10, s. 24 (2).

s. 24. (4) The licensee shall ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act. O. Reg. 79/10, s. 24 (4).

Findings/Faits sayants :

1. Inspector reviewed the 24-hour admission care plan for a resident. The care plan does not identify the resident's risk of falling and interventions to mitigate those risks, the type and level of assistance the resident requires relating to activities of daily living and the resident's diet order including food texture. The licensee failed to ensure the 24-hour admission care plan includes all the required information.

2. Inspector reviewed the admission assessment information provided by the placement coordinator for a resident. This information identifies the resident as being at risk for falls and a history of pain. This information is not included in the resident's care plan. The licensee failed to ensure the care set out in the care plan is based on the information provided by the placement coordinator.

3. Inspector reviewed the 24-hour care plan for a resident. The care plan does not identify any risks the resident poses to the resident or others including interventions to mitigate those risks, the type and level of assistance required to complete activities of daily living and the resident's diet order including diet texture. The licensee failed to ensure the 24-hour admission care plan includes all the required information.

4. Inspector reviewed the admission assessment information provided by the placement coordinator for a resident. This information identifies a risk to the resident and others related to responsive behaviours. This information is not included in the care plan. The licensee failed to ensure the care set out in the care plan is based on the information provided by the placement coordinator.

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 all newly admitted resident have a 24-hour admission care plan which includes the required information, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following subsections:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits sayants :

1. Inspector noted that two newly admitted residents did not have their personal items, including glasses and dentures, labeled within 48 hours of admission. The licensee failed to ensure that a resident's personal items, including personal aids such as dentures and glasses, are labeled within 48 hours of admission.

Issued on this 17th day of June, 2011

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