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

Division des foyers de soins de longue durée
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
Feb 23, 2018	2018_638609_0004	023426-17, 025155-17, 025448-17, 027473-17, 000001-18	Critical Incident System

Licensee/Titulaire de permis

Wikwemikong Nursing Home Limited
2281 Wikwemikong Way P.O. Box 114 Wikwemikong ON P0P 2J0

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

Wikwemikong Nursing Home
2281 Wikwemikong Way P.O. Box 114 Wikwemikong ON P0P 2J0

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

CHAD CAMPS (609), SHELLEY MURPHY (684)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 5-9, 2018.

The following intakes were completed during this Critical Incident System (CIS) inspection:

-Two intakes related to resident falls.
-One intake related to resident to resident abuse.
-One intake related to resident elopement.
-One intake related to an unexpected death of a resident.

A follow-up inspection #2018-638609-0003 was conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Maintenance Manager, Dietitian, Resident Assessment Instrument (RAI) Coordinator, Maintenance staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant internal investigation notes, licensee policies, procedures, programs and resident health care records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan for each resident that set out, the planned care for the resident.

A CIS report was submitted by the home to the Director outlining how resident #002 fell, was taken to hospital and diagnosed with a significant change in health status.

On a particular day Inspector #684 observed resident #002 sitting in the lounge with a specified intervention applied. Later in the day the resident was observed in another location with the specified intervention applied.

During an interview with PSW #012, they indicated that resident #002's fall interventions included the use of the specified intervention. The PSW also indicated that specific resident interventions for falls was found in the kardex and plan of care.

A review of resident #002's current plan of care found no indication that staff were to apply the specified intervention.

A review of the home's policy titled "Assessment and Vital Signs- Resident Care Plan" dated August, 2013 required the resident care plan to provide sufficient information to assist staff to give safe care, which included any risk of falling and interventions to minimize those risks.

During an interview with the RAI Coordinator, they verified that resident #002's current plan of care did not reflect the required specified fall intervention.

During an interview with the DOC, they verified that all interventions should be documented in the resident's plan of care. [s. 6. (1) (a)]

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 there is a written plan for each resident that sets out, the planned care for the resident, to be implemented voluntarily.

Issued on this 23rd day of February, 2018

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

Original report signed by the inspector.