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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 13, 2018	2018_615609_0014	012419-18, 014128-18	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)

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): July 3-6, 2018.

The following intakes were completed during this Critical Incident (CI) System Inspection:

One CI submitted by the home to the Director related to a missing resident; and

One CI submitted by the home to the Director related to resident to resident abuse.

A Complaint #2018_615609_0015 and a Follow Up Inspection #2018_615609_0016 were conducted concurrently with this CI Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Office Manager, Maintenance Manager, 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:
Personal Support Services
Responsive Behaviours

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 O.Reg 79/10, s. 232. Every licensee of a long-term care home shall ensure that the records of the residents of the home are kept at the home. O. Reg. 79/10, s. 232.

Findings/Faits saillants :

1. The licensee has failed to ensure that the records of the residents of the home were kept at the home.

A Critical Incident (CI) report was submitted to the Director by the home which described an incident of responsive behaviours by resident #003 towards resident #004.

Inspector #609 further reviewed the CI report which indicated that staff were performing a specific intervention to ensure other residents' safety from resident #003's responsive behaviours.

A review of resident #003's health care records described in progress notes a history of multiple incidents of responsive behaviours directed towards other residents and that staff were required to perform the specified intervention.

A review of resident #003's entire plan of care (hard and electronic copies) failed to mention anything about the resident requiring the specified intervention until after the CI occurred.

During an interview with PSW #104, they indicated that resident #003 had the specified intervention that was recorded on paper.

During an interview with RPN #101, they verified that resident #003 had the specified intervention that was recorded on paper.

A review of the home's policy titled "Resident Services Manual" last reviewed August 2013 indicated that records containing personal health information were to be retained according to the LTCHA 2007.

During an interview with the DOC, a review of resident #003's entire health care record was performed and found no record (paper or otherwise) that the resident's specified intervention was ever completed.

The DOC acknowledged that the papers for the specified intervention were part of resident's health care record and should not have been missing. [s. 232.]

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 all records of the residents of the home are kept at the home, to be implemented voluntarily.

Issued on this 13th day of July, 2018

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

Original report signed by the inspector.