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 prévue 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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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jun 26, 2019	2019_679638_0004 (A1)	026856-18, 026915-18, 001363-19	Resident Quality Inspection

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

Amended by STEPHANIE DONI (681) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee has requested and been granted an extension for compliance order #001.

Issued on this 26th day of June, 2019 (A1)

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

Original report signed by the inspector.

Ontario

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

Amended by STEPHANIE DONI (681) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): February 4 - 6 and 11 - 15, 2019.

The following intakes were inspected during this Resident Quality Inspection:

-Three logs were related to missing and handling of controlled substances;

-One log was related to a resident's change in condition as a result of a fall;

-One log was related to an allegation of staff to resident abuse;

-One log was related to an incident of resident to resident abuse; and

-One log was a complaint submitted to the Director which was related to allegations of immediate reporting, medication management and care concerns.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Maintenance Manager, Finance Manager, Interim Kitchen Manager, RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aide, Housekeeping Aide, residents and their families.

The Inspector(s) also also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant personnel files, licensee policies, procedures, programs, relevant training and health care records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 23. (1)	CO #001	2018_671684_0021	638
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #002	2018_671684_0021	638

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	Légende 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. 75. Nutrition manager

Specifically failed to comply with the following:

s. 75. (3) The licensee shall ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities. O. Reg. 79/10, s. 75 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a nutrition manager was on site at the home working in the capacity of nutrition manager for the minimum number of hours per week outlined in the O. Reg. 79/10, without including any hours spent fulfilling other responsibilities.

Section 75 subsection (4) of the Ontario Regulation (O. Reg) 79/10, stipulates that a home with 52 residents would require a nutrition manager to be on site and working in the capacity of a nutrition manager for a minimum of 16.64 hours, per week.

Inspector #687 noted that the Administration List for Kitchen Manager (nutrition manager) was vacant. In an interview with Inspector #687, the Administrator stated that the home had a specific licensed bed capacity and a specific number of beds were filled .

In an interview with Inspector #687, Dietary Aide #112 stated that the home currently did not have a Kitchen Manager (nutrition manager).

In an interview with Inspector #687, the Dietary Consultant stated that they were working in the home as a contract worker and their role was to update all the table seating, create snack labels and update the monthly menu. They also stated that they worked in the home once a month for three consecutive days which was equivalent to 24 hours per month.

In an interview with Inspector #687, the Administrator indicated that their previous Kitchen Manager (nutrition manager) ceased their employment with the home in January 2019. The Administrator acknowledged that the home had hired a Dietary Consultant who attended the home once a month, for three consecutive days and worked eight hours each day. The Administrator recognized that the Dietary Consultant was not meeting the minimum hours per week as outlined in the regulations. [s. 75. (3)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 001

WN #2: 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).

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. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

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

Resident #005 was identified as experiencing a change in their continence status on a specific Minimum Data Set (MDS) assessment.

In an interview with Inspector #679, PSW #103 identified that resident #005 was

continent and that they used a specific product to manage their continence. PSW #103 identified that information regarding a resident's continence needs and interventions were outlined in the kardex.

Inspector #679 reviewed the resident's current electronic care plan and kardex and was unable to identify any indication that resident #005 used a specific intervention to manage their continence.

In an interview with Inspector #687, the RAI Coordinator identified that resident #005 required the use of a specific product at specific times during the day, to manage their continence. The RAI Coordinator identified that staff would reference residents' care plans to identify their specific care needs. Inspector #679 and the RAI Coordinator reviewed resident #005's electronic care plan. The RAI Coordinator confirmed that the use of the specific product was not outlined in the resident's plan.

In an interview with Inspector #679, the DOC identified that staff would reference the resident's kardex to identify resident specific care needs. The Inspector and DOC reviewed resident #005's electronic care plan. The DOC confirmed that the use of the specific product should have been included in resident #005's care plan. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A complaint was submitted to the Director alleging that the home had not completed a specific intervention for resident #018.

Inspector #679 reviewed resident #018's physician's orders and identified an order which directed staff to complete a specific intervention on a set schedule. Inspector #679 reviewed resident #018's paper chart and electronic record and identified that the specific intervention was completed on specific dates that was not consistent with the specific intervention's set schedule.

In an interview with Inspector #679, RN #105 identified that resident #018 had an order for the specific intervention on a set schedule. RN #105 identified that once the results of the specific intervention were received, they were scanned into Point Click Care (PCC). The Inspector and the RN reviewed resident #018's electronic records and paper chart. RN #105 confirmed that there were gaps in

the resident's completed specific intervention.

The DOC and Inspector #679 reviewed resident #018's physician's orders for their specific intervention requirements. The Inspector then reviewed the listed results of the specific intervention on PCC. The DOC identified that they were not aware that the specific intervention had not been completed on specific dates and confirmed that it was the expectation that staff were following the physicians orders. [s. 6. (7)]

3. A CIS report was submitted to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital and that resulted in a significant change in the resident's health status. The CIS report identified that resident #003 sustained a fall which resulted in a change in condition.

Inspector #687 reviewed the electronic progress notes which indicated that resident #003 sustained a fall on a specific datel. The electronic progress notes indicated that the resident did not have their specific mobility device at the time of the incident.

Inspector #687 reviewed resident #003's health care records and identified in their electronic care plan, that the staff were advised to encourage the resident to use their specific mobility device and place the device within reach.

In an interview with Inspector #687, PSW #113 stated that they responded to the fall incident and that the resident did not have their specific mobility device at the time of the incident.

In an interview conducted with RN #106, they stated that PSW #113 reported that resident #003 had fallen in a specific location. The RN stated that the resident did not have their specific mobility device with them at the time of the incident.

The home's policy titled "Falls Prevention Program" last revised October 31, 2017, indicated that all staff were to receive education about the falls prevention program at the facility and were to understand the importance of complying with falls interventions.

In an interview with Inspector #687, the DOC stated that staff should have followed the falls prevention interventions implemented for resident #003 which was to ensure that the resident had their specific mobility device within reach, but

the staff did not follow the resident's care plan. [s. 6. (7)]

4. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

During a record review and staff interview with Inspector #638, resident #009 was identified as having two areas of altered skin integrity.

Inspector #638 reviewed resident #009's health care records and identified two physician orders, which directed staff to complete a weekly assessment for the areas of altered skin integrity on the resident.

The Inspector reviewed the resident's electronic treatment administration record (eTAR) for completed weekly wound assessments over a three month period. The Inspector identified that the eTAR record three specific dates in the review period had no documentation to identify the completion and results of the assessment.

The Inspector reviewed the resident's progress notes and identified a notation created on two of the three aforementioned dates, which indicated on both occasions, that the resident's scheduled assessments were changed to be completed on the following date. The Inspector reviewed the resident's health care records and was unable to identify any documentation to support that the assessments had been completed on the next date, or any other date, until the resident's next scheduled assessment.

In an interview with Inspector #638, RN #108 indicated that the PSWs would notify them of any new areas of impaired skin integrity and registered staff would then obtain treatment orders and assess the new area of altered skin integrity. The RN indicated that new areas of altered skin integrity would be identified in the resident's care plan and that assessments should be completed weekly to monitor the wound. The RN stated that these assessments were completed in PCC under the assessments section.

During an interview with Inspector #638, RN #105 indicated that assessments for areas of altered skin integrity were completed weekly and documented under the assessments section of PCC. RN #105 indicated that resident #009 had two areas of altered skin integrity. The Inspector reviewed the aforementioned dates with RN #105, who reviewed the progress notes and assessments section. The RN indicated that they could not be sure if the assessment had been completed

or not, but believed that the registered staff member forgot to document their assessment since the resident's areas of altered skin integrity would have been treated during that period.

In an interview with Inspector #638, the DOC indicated that wounds were assessed on a set schedule and tracked in PCC in the eTAR to prompt staff to ensure that the assessment was not missed. The Inspector reviewed resident #009's eTAR and progress notes related to the aforementioned dates with the DOC. Upon review, the DOC indicated that they expected staff to document the assessments because their belief was that if it was not documented, the care did not occur. [s. 6. (9) 1.]

5. A complaint was submitted to the Director alleging that the home had not completed the prescribed blood work for resident #018. Please refer to WN #2, finding #1 for details.

Inspector #679 reviewed the eTAR for resident #018 and identified a specific task. The Inspector reviewed the eTAR for the period of six and a half months and identified that there was no documentation regarding this task on 17 occasions.

In an interview with Inspector #679, RN #105 identified that there was a task in resident #018's eTAR to prompt the night shift staff to complete the specific task, which was to be completed on a set schedule. The RN indicated that the eTAR notified registered staff to complete the requisition at a specific time, on a set schedule. RN #105 identified to the Inspector that there was documentation missing (which demonstrated the completion of the specific task) on a number of occasions and that it was the expectation that this documentation was completed.

Inspector #679 and the DOC reviewed the eTAR for resident #018 and identified the aforementioned missing documentation. The DOC confirmed that it was the expectation that staff completed the documentation for resident #018 on the eTAR. [s. 6. (9) 1.]

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 the care set out in the plan of care is provided to resident #003 and resident #018, as specified, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any system, the system was complied with.

In accordance with O. Reg. 79/10, s. 89. (1) (a) (iv), the licensee was required to ensure that procedures were developed and implemented to ensure that there was a process to report and locate residents' lost clothing and personal items.

Specifically, staff did not comply with the licensee's policy titled "Procedure for Reporting of Missing Articles" dated August 2013, which was part of the environmental services program.

In multiple interviews with Inspectors #638, #679 and #687, four residents identified to the Inspectors, that they had various articles of missing clothing.

In an interview with Inspector #679, PSW #103 identified that if a resident reported an item as missing, they would search for the residents clothing and inform the laundry department.

In an interview with Inspector #679, RN #105 identified that if a resident reported an item missing, they would get a description of the item and check with the laundry department to try and locate the item. RN #105 identified that they were unsure if the home had a missing clothing log.

Inspector #679 reviewed the policy titled "Procedure for Reporting of Missing Articles" dated August 2013. The policy identified that if a resident or family member reported an article of clothing missing, staff were to report it on the "Missing Item Report Form" and bring the form to the laundry department. The policy then identified that the laundry aide would place the form on the bulletin board in the folding room until the item was found.

Inspector #679 observed the bulletin board in the laundry room and did not observe any missing item reporting forms.

In an interview with Inspector #679, Environmental Service Worker #104 identified that they did not know if there was a place to track missing clothing items. The Inspector and Environmental Service Worker #104 reviewed the home's policy. The Environmental Service Worker identified that they had not seen this form posted on the bulletin board.

In an interview with Inspector #679, the DOC identified that if a resident reported missing clothing they would search the resident's room and report it to nursing staff or maintenance staff. The DOC identified that they were not aware of a formal process for missing clothing. [s. 8. (1) (b)]

2. In accordance with O. Reg 79/10, s. 114 (1), the licensee was required to ensure that written policies and protocols were 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.

Specifically, staff did not comply with the licensee's policy regarding "Shift Change Monitored Drug Count – Section 6 Policy 6-6", last revised January 2018, which was part of the licensee's medication management system.

A CIS report was submitted to the Director related to an incident where it was identified that a resident was missing a specific controlled substance during a medication count.

The Inspector reviewed a disciplinary letter which identified on a specific date a specific controlled substance was identified as missing at the end of the shift. The letter stated that the RN failed to follow the nursing home's policy, which was to notify the DOC immediately. The letter further stated that the RN left the building without the drug being found which was also against policy.

The home's policy titled "Shift Change Monitored Drug Count – Section 6 Policy 6 -6", last revised January 2018, indicated that staff were to report any discrepancies to the Nurse Manager, Director of Care (or delegate) immediately.

Inspector #638 reviewed resident #001's health care records and identified a physician's which directed staff to administer a specific controlled substance at a specific time each day.

In an interview with Inspector #638, RN #105 indicated that controlled substances were stored and locked in a specific area. The RN indicated that registered staff were supposed to complete a count of all controlled substances at specific times. In a separate interview, the RN indicated that if a discrepancy was identified, they would notify the DOC.

During an interview with Inspector #638, the DOC indicated that they became aware of this incident when they were working a shift as a registered staff member. The DOC indicated they went to sign off on a medication and identified missing documentation on specific medications when RN #118 was working. The DOC identified that one specific medication was missing from the medication card and that there was no documentation to support the medication had been given. The DOC stated they never found the missing medication and that staff did not follow the home's policy when they did not report the discrepancy to the DOC. [s. 8. (1) (b)]

3. In accordance with O. Reg 79/10, s. 68 (2) (e), the licensee was required to ensure that the program of nutrition care and hydration included a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter.

Specifically, staff did not comply with the licensee's policy regarding "Assessment and Vital Signs – Vital Signs" which indicated that all residents were to be weighed on admission and monthly to monitor significant weight changes. The policy stated that PSWs were responsible to ensure that all residents were weighed monthly and that the weights were completed during the first week of each month. The policy identified that registered staff were responsible for ensuring that all weights were completed and recorded in the resident health record.

During a record review of resident health care records in PCC, Inspectors #638, #679, #687 each identified that the majority of the resident's in the review did not have a recorded weight for one specific month.

Inspector #638 reviewed a weight entry audit report for the specific month. The Inspector identified that three out of 52 residents (six per cent) had their weight recorded in PCC for the month.

In an interview with Inspector #638, PSW #101 indicated that resident's were weighed during the first week of each month. The PSW stated that they weighed residents and recorded the weights on a paper record which was then given to registered staff to transcribe into PCC.

During an interview with Inspector #638, RN #105 indicated that weights were recorded monthly. The RN stated that the PSWs took resident weights and wrote down the results on a paper which was then transcribed into PCC by registered staff. Upon reviewing the specific month, PCC weight records with the RN, they reviewed the paper records they maintained, and identified that they believed the paper record must have gone missing due to the number of missed weights for that month. The RN indicated that weights were supposed to be documented monthly, usually within the first week of the month.

In an interview with Inspector #638, the DOC indicated that PSWs took resident weights monthly during the first week of each month. Upon reviewing the specific month's weights with the DOC, they indicated that they recalled a staff member telling them that the paper record for December was lost and they directed staff to re-weigh the residents. The DOC could not recall when they identified the record was missing and had directed staff to re-weigh the residents but could have already been the next month. The DOC indicated that resident weights were

expected to be taken and recorded monthly. [s. 8. (1) (b)]

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 staff comply with the home's policy titled "Shift Change Monitored Drug Count – Section 6 Policy 6-6", to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home were kept in good repair, excluding the residents' personal aids or equipment.

Inspector #687 observed resident #004, resident #014 and resident #024 with their bed frame missing mattress keepers, which rendered the mattress unsecured.

Inspector #679 observed that resident #003, resident #008, resident #023 and resident #025 were also missing their mattress keepers from their bed frame, which rendered their mattress unsecured. Furthermore, the Inspector identified that;
-resident #003's bed had a significant gap between the mattress and foot board;
-resident #023's bed had a significant gap between the mattress and the foot board;
-resident #025's bed had a significant gap between the mattress and foot board; and
-resident #004's bed had a significant gap between the mattress and the head board.

The home's policy titled "Preventative Maintenance Program" date of origin August 2013, indicated that "A well-structured program pre-plans the preventative work to be done on a given piece of equipment and schedule maintenance work to be done. This equates to a better, safer and fresher environment for our residents and staff".

In an interview with Inspector #687, the Maintenance Manager stated that they only conducted a bed safety check whenever a resident was newly admitted. They stated that they were not aware of the missing mattress keepers from the resident beds and acknowledged that the mattresses were not secured in the bed frame and posed a risks to the residents. The Maintenance Manager further indicated that they would secure the mattresses immediately. [s. 90. (2) (b)]

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 procedures are implemented to ensure that all equipment are kept in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

Inspector #638 requested the written record of the quarterly review of the medication incidents and adverse drug reactions that had occurred in the home since the last review.

The Inspector reviewed the previous quarterly PAC meeting held in October 2018. The Inspector was unable identify any record to indicate that the previous medication incidents had been reviewed during the meeting.

In an interview with Inspector #638, the DOC indicated that they had just started their roll as DOC when the most recent PAC meeting was held. Upon reviewing the PAC meeting binder and records, the DOC indicated that they reviewed all medication incidents and analyzed them for trends to minimize potential future risk, but at their first meeting, they were not aware of this requirement and a review of all the medications and adverse drug reactions did not occur as part of the October 2018, quarterly review. [s. 135. (3)]

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 quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings, and equipment were maintained in a good state of repair.

During a dining room observation by Inspector #687, the Inspector observed two stools being used by PSWs to assist residents in one specific dining room lounge. The stools were noted to be in disrepair, as the upholstery was significantly damaged and the substrate foam was exposed.

In an interview with Inspector #687, PSW #102 stated that the two stools in one specific dining room lounge that were used by staff members had been in a state of disrepair for more than six months. The PSW further stated that they were uncertain if this was reported to management.

In an interview with Inspector #687, the Maintenance Manager acknowledged that the stools in the specific dining room lounge were in a state of disrepair and had been for more than six months. The Maintenance Manager stated that they would remove and replace the stools in the specific dining room lounge. [s. 15. (2) (c)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for the assessment of continence.

Resident #005 was identified as experiencing a change in their continence status on a specific Minimum Data Set (MDS) assessment.

Inspector #679 reviewed the admission and quarterly review MDS assessment which identified that the resident had a specific level of continent for bowel and bladder. Alternatively, upon review of the corresponding Point of Care (POC) charting, it was identified that the resident had a specific level of continence, contrary to the MDS assessment.

Inspector #679 reviewed the resident's electronic assessments and was unable to identify a completed continence assessment for resident #005, since their admission to the home.

In an interview with Inspector #679, PSW #109 identified that resident #005 had a specific level of continence, which reflected the POC charting.

In an interview with Inspector #679, RN #105 identified that they believed that resident #005 had a specific level of continence, reflected in the POC charting. The RN identified that continence assessments were completed on admission and whenever there was a change in a resident's continence status. The

Inspector and RN #105 reviewed resident #005's electronic health care records and did not identify any completed continence assessment on the resident. RN #105 confirmed that a continence assessment should have been completed for resident #005.

The home's policy titled "Resident Care Programs: Continence Improvement Program" last revised April 2018, identified that the registered nursing staff were to conduct a bladder assessment using a clinically appropriate assessment instrument on admission, quarterly and after any change in condition that may affect bladder or bowel.

In an interview with Inspector #679, the DOC identified that continence assessments were to be completed upon admission. The Inspector and DOC reviewed resident #005's electronic assessments and identified that a continence assessment had not been completed on the resident. The DOC confirmed that a continence assessment should have been completed for resident #005. [s. 51. (2) (a)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. The licensee has failed to comply with the following requirement of the LTCHA; it is a condition of every license that the licensee shall comply with every order made under this Act.

Compliance order #002 was served to the home on October 4, 2018, from inspection report #2018_671684_0021, with a compliance due date of November 30, 2018. A section of the order directed the home to "ensure that all staff who are responsible for submitting critical incidents to the Director are trained on the requirements for reporting and that a record of when the training occurred and who the training is provided to, is to be maintained.

Inspector #638 reviewed the "Wikwemikong Nursing Home Action Plan – MOH Inspection Date: September 18 – 21, 2018" which indicated that all registered staff were to receive education related to critical incident systems including; when to submit a CIS; how to locate the CIS form on-line; Critical Incident vs Mandatory Reporting; and how to complete a CIS. The plan identified that the DOC was to document training sessions, dates, times and attendance at sessions.

The Inspector requested the training records related to CIS reporting from the DOC on February 13, 2019. Upon review of the completed training records it was identified that only two registered staff members had signed the CIS reporting document.

During an interview with Inspector #638, RN #105 indicated that they received training related to their roles and expectations for critical incidents that required immediate reporting. The RN reviewed, with the Inspector, a binder which had tools and resources for registered staff to review in order to properly report critical incidents as per the requirements.

In an interview with Inspector #638, the DOC indicated that they had provided abuse and neglect, resident rights and CIS reporting training together in October 2018. Upon reviewing the documentation records with the DOC it was identified that the registered staff members had signed off on one of the training records (abuse and neglect) and assumed that they only had to sign one record to acknowledge their attendance. The Inspector reviewed the plan submitted by the home with the DOC who indicated that they did not follow their plan to maintain a record of the CIS reporting training, but all registered staff did receive the required training as ordered. [s. 101. (3)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A CIS report was submitted to the Director related to a missing narcotic. The report identified that the registered staff member removed a specific controlled substance from a resident's medication card which fell into a crevice in the medication cart.

The Inspector reviewed resident #011's health care records and identified a physician order which directed staff to administer a specific controlled substance at a specific time. The Inspector reviewed the eMAR and progress notes. The eMAR identified the medication as given.

The Inspector reviewed the Medication Incident Report and identified that RN #119 reported themselves for missing resident #011's scheduled controlled substance dosage.

In an interview with Inspector #638, RN #105 indicated that the resident's eMAR was based on physician orders which were transcribed into the record once the order was received. The RN stated that staff were expected to follow the physician's orders and if an ordered medication was not given at the scheduled time, it was considered a medication incident.

The home's policy titled "Medication Administration – Routines – 690" indicated that each resident shall receive medication and treatment as ordered by the physician, unless the resident refuses.

During an interview with Inspector #638, the DOC indicated that the staff became aware of the incident when the resident reported to the registered staff that they did not receive their scheduled medication. The DOC stated that they had searched the medication cart once it was identified that the resident stated they did not receive the medication and that the medication card was missing the scheduled medication. The DOC indicated that they located the scheduled medication in a crevice of the cart and that the medication must have fallen into the crack when staff were preparing the resident's scheduled medications for administration. When asked if the home was supposed to ensure that drugs were administered as per the prescriber's orders, the DOC stated yes. [s. 131. (2)]

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Issued on this 26th day of June, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by STEPHANIE DONI (681) - (A1)
Inspection No. / No de l'inspection :	2019_679638_0004 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	026856-18, 026915-18, 001363-19 (A1)
Type of Inspection / Genre d'inspection :	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 26, 2019(A1)
Licensee / Titulaire de permis :	Wikwemikong Nursing Home Limited 2281 Wikwemikong Way, P.O. Box 114, Wikwemikong, ON, P0P-2J0
LTC Home / Foyer de SLD :	Wikwemikong Nursing Home 2281 Wikwemikong Way, P.O. Box 114, Wikwemikong, ON, P0P-2J0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cheryl Osawabine-Peltier

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 75. (3) The licensee shall ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities. O. Reg. 79/10, s. 75 (3).

Order / Ordre :

The licensee must be compliant with s. 75 (3) of the O. Reg. 79/10. Specifically, the licensee must;

a) ensure that the home maintains a nutrition manager who is an active member of the Canadian Society of Nutrition Management or a Registered Dietitian; and

b) ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities.

Grounds / Motifs :

1. The licensee has failed to ensure that a nutrition manager was on site at the home working in the capacity of nutrition manager for the minimum number of hours per week outlined in the O. Reg. 79/10, without including any hours spent fulfilling other responsibilities.

Section 75 subsection (4) of the Ontario Regulation (O. Reg) 79/10, stipulates that a home with 52 residents would require a nutrition manager to be on site and working in the capacity of a nutrition manager for a minimum of 16.64 hours, per week.

Inspector #687 noted that the Administration List for Kitchen Manager (nutrition manager) was vacant. In an interview with Inspector #687, the Administrator stated that the home had a specific licensed bed capacity and a specific number of beds were filled .

In an interview with Inspector #687, Dietary Aide #112 stated that the home currently did not have a Kitchen Manager (nutrition manager).

In an interview with Inspector #687, the Dietary Consultant stated that they were working in the home as a contract worker and their role was to update all the table seating, create snack labels and update the monthly menu. They also stated that they worked in the home once a month for three consecutive days which was equivalent to 24 hours per month.

In an interview with Inspector #687, the Administrator indicated that their previous Kitchen Manager (nutrition manager) ceased their employment with the home in January 2019. The Administrator acknowledged that the home had hired a Dietary Consultant who attended the home once a month, for three consecutive days and worked eight hours each day. The Administrator recognized that the Dietary Consultant was not meeting the minimum hours per week as outlined in the regulations.

The severity of this issue was determined to be a level two, as there was the potential for actual harm to the residents of the home. The scope of the issues was a level three, as it was identified that all the resident's in the home were potentially affected. The home had a level two compliance history, as they had no previous non-compliance within this section of O. Reg. 79/10. (687)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Aug 30, 2019(A1)

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 services for the Licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 26th day of June, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by STEPHANIE DONI (681) - (A1)

Service Area Office / Bureau régional de services : Sudbury Service Area Office