Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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 rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 22, 2020	2020_671684_0002	021699-19	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

SHELLEY MURPHY (684), 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): January 13 to 17, 2020.

The following intake was inspected during this Critical Incident Inspection:

-One log related to an incident that caused an injury to a resident.

A Service Area Office initiated inspection #2020_671684_0001, was conducted concurrently with this Critical Incident Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Finance Officer, Maintenance Supervisor, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Cook, Housekeeper, Activity Aides (AAs), and residents.

The Inspectors also conducted daily tours of the resident care ares, observed the provision of care and services to residents, reviewed policies, procedures, home investigation files and resident health care records.

The following Inspection Protocols were used during this inspection:
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff involved in the different aspects of care collaborated with each other in the development and implementation of resident #001's plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

A Critical Incident (CI) report was submitted by the home to the Director, which outlined how on a specified date in 2019, a incorrect intervention was completed involving resident #001, by two Activity Aides (AAs) while they were attending a program.

During an interview with Inspector #609, resident #001 described how they should not have received a specific medication on the day of the incident.

During an interview with Registered Nurse (RN) #115, they described how certain medications were typically provided in the mornings and evenings and should be held for reasons specified. The RN further described that they were usually made aware in advance when certain medications were to be held.

A review of resident #001's Electronic Medication Administration Record (EMAR) found that on a specified date in 2019, the resident was given a prescribed medication in the morning.

During an interview with AA #113, they described how resident #001 attended programs previously without any difficulties. The incident occurred because a prescribed medication was administered to the resident the day of the incident, because the AA had forgotten to provide the registered staff with a list of which residents who were attending to the program. As a result, the nurse did not know whose medications needed to be held and provided resident #001 with their medication as prescribed.

When asked for the home's plan of care policy, the DOC advised the Inspector that the home did not have a written policy or procedure on plans of care.

During an interview with the DOC, they indicated that the AAs and registered staff did not collaborate with each other in their assessments of resident #001, when the nurse was not informed by the AAs that the resident was attending a program that day and required their medication to be held. [s. 6. (4) (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 involved in the different aspects of care collaborated with each other in the development and implementation of resident #001's plan of care, so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #001.

A CI report was submitted by the home to the Director which outlined how resident #001 was improperly transferred by two AAs, while attending a program. The home's investigation found that the improper transfer had resulted in a change in the resident's condition.

Inspector #609 reviewed resident #001's plan of care at the time of the incident, which directed staff on the type of transfer the resident required.

During an interview with resident #001, they recalled the incident when they were attending a program and requested the two AAs to transfer them. When they lifted the resident they noted a change in the resident's condition.

During interviews with AA (#112 and #113), both indicated that they were conducting a program when resident #001 requested they transfer them. Both AAs acknowledged that the resident required a specific transfer intervention, yet performed another type of transfer. The AAs described how the resident indicated their change in their condition.

When asked for the home's policy on safe transferring and positioning techniques, the DOC advised the Inspector that the home did not have a written policy or procedure on safe transferring and positioning techniques.

During an interview with the DOC, they indicated that the two AAs should not have transferred resident #001 during the program, because they did not have the proper equipment necessary to safely transfer the resident. [s. 36.]

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 use safe transferring and positioning devices or techniques when assisting resident #001, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident in the home no later than one business day after the occurrence of an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition, followed by the report required under subsection (4).

A CI report was submitted by the home to the Director on a specified date in 2019, which outlined how on a earlier date in 2019, resident #001 was improperly transferred by two AAs which resulted in the resident having a change in condition.

Inspector #609 reviewed resident #001's health care records and found documentation from a specified date in 2019, which indicated that the resident had a change in condition.

A review of the home's policy titled "Critical Incidents" (no revision date) indicated that the Director would be informed within one business day of "an injury in respect of which a person [was] taken to the hospital".

During an interview with the DOC, they verified that they were aware that resident #001 was taken to the hospital in 2019, for an assessment. On a specified date in 2019, the hospital called and informed the home that the resident had a change in condition. The DOC further verified that they reported the injury to the Director several days later, because they thought that the CI report only needed to be submitted once the home's internal investigation of the incident was completed. [s. 107. (3) 4.]

Issued on this 23rd day of January, 2020

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

Original report signed by the inspector.