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

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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_0001	000306-20	Other

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 an Other inspection.

This inspection was conducted on the following date(s): January 13-17, 2020.

This inspection is a Service Area Office initiated inspection.

A Critical Incident System inspection #2020_671684_0002, was conducted concurrently with this Service Area Office initiated 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 areas, observed the provision of care and services to residents, reviewed relevant policies, procedures, home investigation files and resident health care records.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Medication
Reporting and Complaints
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 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. (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).

Findings/Faits saillants :

1. 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.

While reviewing a fall with injury as a component of the Service Area Office (SAO) initiated inspection, Inspector #684 noted that resident #005's care was not provided as per their plan of care.

Inspector #684 reviewed documentation from Point Click Care (PCC) which indicated that resident #005 did not have care plan interventions in place at the time of the incident, and PSW #111 admitted they forgot to put the specified care plan intervention in place.

During an interview with Personal Support Worker (PSW) #111, Inspector #684 asked what they remembered about the incident involving resident #005. The Inspector asked if the care plan interventions were in place at the time of the incident involving resident #005, PSW #111 stated, I can't fully remember now, but if it was charted that I forgot then maybe I did forget.

Inspector #684 interviewed Registered Nurse (RN) #108 and asked can you tell me what happened in the incident involving resident #005. RN #108 stated, I was going by resident #005's room and the resident was yelling, I noted that specified care plan interventions were not in place. PSW #111 told RN #108, that they would admit that they forgot to use the intervention as specified in the care plan.

Inspector #684 reviewed the home's policy titled "Falls Prevention and Restraint Reduction Program", with a release date of October 31, 2017. The policy stated, "Health Care Aides (HCAs)/Personal Support Workers (PSW); Follow the interventions as outlined on the care plan".

Inspector #684 interviewed the Director of Care (DOC) and together they reviewed the PCC progress notes for the incident involving resident #005. The DOC stated, the PCC notes indicated that at the time of the incident resident #005 did not have care plan interventions in place as specified. The DOC stated that post incident it was reported that the PSWs had forgotten to put the specified care plan intervention in place and shortly thereafter resident #005 was involved in the incident. The DOC stated that the PSWs did not follow the care plan interventions for resident #005. [s. 6. (7)]

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 the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents and that those doors were kept closed and locked when they were not being supervised by staff.

During the initial tour of the home, Inspector #609 observed the following:

-The door to the laundry room, which housed the laundry shoot leading to the basement was unlocked and unattended. The key to the laundry room was noted hanging on a chain beside the door;
-The door to the linen room, which housed the home's electrical breakers was open, unlocked, unattended and the lock was broken;
-The door to the beauty parlour, which housed hair cutting supplies and equipment was unlocked, unattended and the lock was broken;
-The doors to the home's four tub and shower rooms were locked via sliding barrel bolts affixed to the outside of the doors; and
-The door to the housekeeping room, which housed cleaning equipment and chemicals was also locked via a sliding barrel bolt affixed to the outside of the door.

During an interview with Housekeeper #103, they verified that the laundry room door should have been locked and proceeded to lock the door. The Housekeeper also verified that the linen room door was open, that the door frame was warped, therefore the door would not shut. They then manually pulled the door closed.

When asked for the home's policy on doors in the home, the DOC advised the Inspector that the home did not have a written policy or procedure related to doors.

During an interview with the DOC, they verified that the doors to the linen room and beauty parlour were to be locked when not attended by staff and acknowledged that their locks were not working. The DOC further verified that the tub, shower, housekeeping and laundry rooms were non-residential areas and that some residents (like resident #007) could slide the barrel bolts or use the key outside the laundry room to unlock the doors. The DOC indicated that they would be collaborating with the Maintenance Supervisor to come up with solutions to ensure residents did not have access to non-residential areas. [s. 9. (1) 2.]

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 that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents and that those doors are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents had a screen and could not be opened more than 15 centimetres (cm).

a) During the initial tour of the home, Inspector #609 observed windows, in the home's television lounge, activity room (Sunshine Café), two dining rooms and all resident rooms had windows that opened greater than 15 cm. This was despite plastic stoppers which the windows slid over to open fully.

When the Inspector fully opened the windows, they would leave the frame, swing in and downward and if not grabbed, would have struck the Inspector in the head.

When asked for the home's policy on windows in the home, the DOC advised the Inspector that the home did not have a written policy or procedure related to windows.

During an interview with the DOC and Maintenance Supervisor, they both verified that the home's windows that were accessible to residents could open greater than 15 cm and that when fully opened, the window would fall inwards, potentially striking whoever opened the windows.

Both the DOC and the Maintenance Supervisor indicated that they were unaware that resident accessible windows in the home were not to open greater than 15 cm.

b) On a specified date in 2020, during the initial tour of the home, Inspector #609 observed that one of the two windows in the Sunshine Café did not have a screen applied.

Inspector #609 noted that the windows in three random resident rooms in each of the home's five Zones were observed to ensure screens were applied. All windows in the television lounge, Sunshine Café and both dining rooms were also observed for screens.

Of the 46 windows observed, four or nine per cent did not have screens applied.

During an interview with the Maintenance Supervisor, they verified four windows did not have screens applied. They indicated that three did not have screens because air conditioners were placed in the windows during the summer and that the one must have fallen out. The Maintenance Supervisor indicated that they were aware that all resident accessible windows required screens.

During an interview with the DOC, they verified that all resident accessible windows required screens and had advised the Maintenance Supervisor to have them installed. [s. 16.]

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 every window in the home that opened to the outdoors and is accessible to residents has a screen and can not be opened more than 15 centimetres (cm), 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:

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 O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids labelled within 48 hours of admission and of acquiring, in the case of new items.

During the initial tour of the home, Inspector #609 observed the following:

-Two used unlabeled barrier creams in a bathroom;
-Two used unlabeled urinals and a used unlabeled bedpan in a shared room;
-One used unlabeled Listerine bottle in a shared room;
-Numerous used unlabeled electric razors on a cart across from the home's Tuck Shop.

During an interview with PSW #107, they verified that all residents' personal items such as urinals, bedpans, lotions, mouthwash and electric razors were to be labeled with the residents' names.

When asked for the home's policy on labeling of residents' personal items the DOC advised the Inspector that the home did not have a written policy or procedure on labeling residents' personal items.

During an interview with the DOC, they verified that there were used, unlabeled personal resident items identified during the initial tour and that they should have been labeled with the residents' names. [s. 37. (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 ensuring that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

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.