Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELISSA CHISHOLM (188), JESSICA LAPENSEE (133)
Inspection No. / No de l'inspection :	2013_099188_0014
Log No. / Registre no:	S-000073-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 30, May 29, 2013
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 :	~~ROSELLA KINOSHAMEG~~ Hali Pitwawankwat (Acting)

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

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

Ministére de la Santé et des Soins de longue durée

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 : 901

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 70. (1) Every licensee of a long-term care home shall ensure that the home has an Administrator. 2007, c. 8, s. 70. (1).

Order / Ordre :

The licensee shall ensure there is a person working in the capacity of Administrator on site at the home. The licensee shall ensure the Administrator works on site at the home at least 16 hours per week. The licensee shall notify Linda Toner, Manager, Sudbury Service Area Office by 16:00h May 1, 2013, in writing regarding who will be acting in the capacity of Administrator.

Grounds / Motifs :

1. Inspector #188 and #133 entered the home April 30, 2013 at approximately 09:30h. Upon entrance inspectors approached the nursing desk and were informed by two staff members that currently there is no Administrator or Director of Nursing and Personal Care (DONPC). Inspectors were informed that since the resignation of the previous Administrator/DONPC on April 18, 2013 that no one has been working in these roles. Inspectors spoke with the office manager who also confirmed that currently there is no one working, acting or permanently, in the roles of Administrator or DONPC. The licensee failed to ensure that the home has an Administrator. (188)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 01, 2013

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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 : 902

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 71. (1) Every licensee of a long-term care home shall ensure that the long-term care home has a Director of Nursing and Personal Care. 2007, c. 8, s. 71. (1).

Order / Ordre :

The licensee shall ensure there is a person working in the capacity of Director of Nursing and Personal Care on site at the home. The licensee shall ensure the Director of Nursing and Personal Care works on site at the home at least 24 hours per week. The licensee shall notify Linda Toner, Manager, Sudbury Service Area Office by 16:00h May 1, 2013, in writing regarding who will be acting in the capacity of Director of Nursing and Personal Care.

Grounds / Motifs :

1. Inspector #188 and #133 entered the home April 30, 2013 at approximately 09:30h. Upon entrance inspectors approached the nursing desk and were informed by two staff members that currently there is no Administrator or Director of Nursing and Personal Care (DONPC). Inspectors were informed that since the resignation of the previous Administrator/DONPC on April 18, 2013 that no one has been working in these roles. Inspectors spoke with the office manager who also confirmed that currently there is no one working, acting or permanently, in the roles of Administrator or DONPC. The licensee failed to ensure that the home has a Director of Nursing and Personal Care. (188)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 01, 2013

Order # /
Ordre no : 903

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee will immediately ensure that there is at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home scheduled to be on duty and present in the home at all times, except as provided in the regulations. The licensee shall provide Linda Toner, Manager, Sudbury Service Area Office by 16:00h May 1, 2013, with a copy of the schedule up to May 31, 2013 that demonstrates at least one registered nurse will be on duty and present in the home at all times.

Grounds / Motifs :

1. Inspector 188 and 133 spoke with the Office Manager who identified himself along with two registered staff members developed the current nursing schedule which ends May 11, 2013 was developed. He further identified there is not anyone specifically assigned to this task and that he is unsure when or who will develop the next schedule and that this task was previously assigned to the Director of Nursing and Personal Care, who has resigned and currently no one is acting in the role. (188)

2. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c8, in that there was not a registered nurse on duty at the home for a twelve hour period on April 29th, 2013 and there is no registered nurse on duty at the time of the inspection, on April 30th 2013.

Inspector #133 and #188 arrived at the home at approximately 09:30h on April 30th, 2013. The inspectors were made aware that while there was a registered nurse in the building, they were leaving momentarily as they were to have finished work at 07:00h. The inspectors were informed that there was no registered nurse coming in for the 07:00h-19:00h shift. The inspectors obtained the staffing schedule from the office manager and confirmed that there is no registered nurse scheduled for the 07:00h-19:00h shift on April 30th, 2013. The inspectors also noted that there was no registered nurse scheduled for the 07:00h-19:00h shift on Monday April 29th, 2013. The inspectors further noted that there was no Administrator or Director of Nursing and Personal Care (DONPC) in the home at the time of the inspection and that no one has worked in the role of Administrator or DONPC since the resignation of the former Administrator/DONPC on April the 18th, 2013. (133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 01, 2013

Order # /
Ordre no : 001

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

Linked to Existing Order /
Lien vers ordre existant: 2013_099188_0014, CO #903;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee will take immediate action to ensure that there is at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home scheduled to be on duty and present in the home at all times, except as provided in the regulations. The licensee shall provide Linda Toner, Manager, Sudbury Service Area Office by 16:00h June 7, 2013, with a copy of the schedule up to June 30, 2013 that demonstrates at least one registered nurse will be on duty and present in the home at all times.

Grounds / Motifs :

1. CO #903 issued on April 30, 2013 required the licensee to submit a copy of the schedule ensuring a registered nurse will be on duty and present in the home at all times. This was to be submitted by May 1, 2013 at 16:00h. The licensee did not submit a copy of the schedule as required by the compliance order. Further, despite multiple requests by the inspector, the licensee did not submit a copy of the schedule demonstrating at least one registered nurse would be on duty and present in the home at all times until May 21, 2013. (188)

2. Inspector 188 and 133 spoke with the Office Manager who identified that himself, along with two registered staff members developed the current nursing schedule which ends May 11, 2013. He further identified there is not anyone specifically assigned to this task and that he is unsure when or who will develop the next schedule and that this task was previously assigned to the Director of Nursing and Personal Care, who has resigned and currently no one is acting within the role. (188)

3. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c8, in that there was not a registered nurse on duty at the home for a twelve hour period on April 29th, 2013 and there is no nurse on duty at the time of the inspection, on April 30th 2013.

Inspector #133 and #188 arrived at the home at approximately 0930 on April 30th, 2013. The inspectors were made aware that while there was a registered nurse in the building, they were leaving momentarily as they were suppose to have been off work at 0700. The inspectors were informed that there was no registered nurse coming in for the 0700-1900 shift. The inspectors obtained the staffing schedule from the office manager and confirmed that that there is no registered nurse scheduled for the 0700-1900 shift on April 30th, 2013. The inspectors also noted that there was no registered nurse scheduled for the 0700 -1900 shift on Monday April 29th, 2013. (133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 14, 2013

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 30th day of April, 2013

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : MELISSA CHISHOLM

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 30, May 29, 2013	2013_099188_0014	S-000073-13	Complaint

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

MELISSA CHISHOLM (188), JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 30th, May 1st-2nd, 2013

During the course of the inspection, the inspector(s) spoke with Board of Management Members, the Dietary Manager, the Manager of Environmental Services, the Office Manager, Registered Nursing staff, Personal Support Workers, the Physiotherapy Assistant, the complainants and residents.

During the course of the inspection, the inspector(s) reviewed written complaints, reviewed the nursing and personal support services schedules, conducted a walk through of resident care areas, observed staff to resident interactions, observed meal service, reviewed resident health care records and reviewed the home's 24 hour unit report.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance

Critical Incident Response

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 70. Administrator

Specifically failed to comply with the following:

s. 70. (1) Every licensee of a long-term care home shall ensure that the home has an Administrator. 2007, c. 8, s. 70. (1).

Findings/Faits saillants :

1. Inspector #188 and #133 entered the home April 30, 2013 at approximately 09:30h. Upon entrance inspectors approached the nursing desk and were informed by two staff members that currently there is no Administrator or Director of Nursing and Personal Care (DONPC). Inspectors were informed that since the resignation of the previous Administrator/DONPC on April 18, 2013 that no one has been working within the role. Inspectors spoke with the office manager who also confirmed that currently there is no one working, acting or permanently, within the role of Administrator or DONPC. The licensee failed to ensure that the home has an Administrator. [s. 70. (1)]

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 71. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the long-term care home has a Director of Nursing and Personal Care. 2007, c. 8, s. 71. (1).

Findings/Faits saillants :

1. Inspector #188 and #133 entered the home April 30, 2013 at approximately 09:30h. Upon entrance inspectors approached the nursing desk and were informed by two staff members that currently there is no Administrator or Director of Nursing and Personal Care (DONPC). Inspectors were informed that since the resignation of the previous Administrator/DONPC on April 18, 2013 that no one has been working within the role. Inspectors spoke with the office manager who also confirmed that currently there is no one working, acting or permanently, within the role of Administrator or DONPC. The licensee failed to ensure that the home as an Administrator. [s. 71. (1)]

Additional Required Actions:

CO # - 902 was served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c8, in that there was not a registered nurse on duty at the home for a twelve hour period on April 29th, 2013 and there is no nurse on duty at the time of the inspection, on April 30th 2013.

Inspector #133 and #188 arrived at the home at approximately 0930 on April 30th, 2013. The inspectors were made aware that while there was a registered nurse in the building, they were leaving momentarily as they were supposed to have been off work at 0700. The inspectors were informed that there was no registered nurse coming in for the 0700-1900 shift. The inspectors obtained the staffing schedule from the office manager and confirmed that that there is no registered nurse scheduled for the 0700-1900 shift on April 30th, 2013. The inspectors also noted that there was no registered nurse scheduled for the 0700-1900 shift on Monday April 29th, 2013. [s. 8. (3)]

2. Inspector 188 and 133 spoke with the Office Manager who identified that himself, along with two registered staff members developed the current nursing schedule which ends May 11, 2013. He further identified there is not anyone specifically assigned to this task and that he is unsure when or who will develop the next schedule and that this task was previously assigned to the Director of Nursing and Personal Care, who has resigned and currently no one is acting within the role. [s. 8. (3)]

3. CO #903 issued on April 30, 2013 required the licensee to submit a copy of the schedule ensuring a registered nurse will be on duty and present in the home at all times. This was to be submitted by May 1, 2013 at 16:00h. The licensee did not submit a copy of the schedule as required by the compliance order. Further, despite multiple requests by the inspector, the licensee did not submit a copy of the schedule demonstrating at least one registered nurse would be on duty and present in the home at all times until May 21, 2013. [s. 8. (3)]

Additional Required Actions:

CO # - 903 was served on the licensee. CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. Inspector reviewed the health care record for resident #20 on May 1, 2013. Inspector noted this resident sustained a fall and head injury and was transferred to hospital for further assessment. Inspector was unable to locate a post-fall assessment using a clinically appropriate assessment instrument. The licensee failed to ensure that when a resident has fallen a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls. [s. 49. (2)]

2. Inspector reviewed the health care record for resident #18 on May 1, 2013. Inspector noted this resident sustained a fall resulting in a head injury and transfer to hospital. Inspector was unable to locate a post-fall assessment using a clinically appropriate assessment instrument. Inspector spoke with staff #101 who confirmed there was no post-fall assessment and was unable to offer any explanation why it wasn't completed. The licensee failed to ensure that when a resident has fallen a post -fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls. [s. 49. (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 when resident #18, #20 or any resident of the home has fallen that the resident is assessed using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 101(1)(3) in that responses were not made to persons who made a complaint.

At a Board of Directors (Board) meeting on March 20th, 2013, the licensee received three written complaints related to the care of residents from three individual informants. On May 2nd, 2013, Inspector #133 interviewed a member of the Board and inquired if the informants had been provided with a response to their complaints. The Board member indicated that a response had not been provided to the informants. The informants did not receive a response to their complaints from any other source. [s. 101. (1) 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 ensure that a response is provided to any person who makes a complaint, to be implemented voluntarily.

WN #6: 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):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours. O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. Inspector was informed by a staff member that there were unreported critical incidents since the home's Director of Nursing and Personal Care had resigned. Inspector reviewed the home's 24 hour nursing report on May 1, 2013 and noted resident #18 sustained a fall resulting in an injury to his head and hip pain on April 17, 2013. Inspector noted the resident was transferred to the hospital for further assessment. Inspector reviewed the critical incident reports submitted by the home and noted no report was received related to this resident's incident. The licensee failed to ensure that the Director is informed no later than one business day following an injury in which a person is taken to the hospital. [s. 107. (3)]

2. Inspector reviewed the health care record of resident #20 on May 1, 2013. Inspector noted this resident sustained a fall and head injury on March 29, 2013 and was transferred to hospital for further assessment. Inspector reviewed the critical incident reports submitted by the home and noted no report was received related to this resident's incident. The licensee failed to ensure that the Director is informed no later than one business day following an injury in which a person is taken to the hospital. [s. 107. (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 ensuring the Director is informed no later than one business day following an injury in which a person is taken to the hospital, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. Complainants provided to the inspector copies of three written complaints that were submitted to the Board on March 20, 2013. Inspector noted these written complaints included allegations of abuse, improper resident care and the operation of the home. These written complaints were never forwarded to the Director from the home. The licensee failed to ensure that any written complaint that has been received by the home concerning the care of a resident or the operation of the home is immediately forwarded to the Director. [s. 22. (1)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. Inspector was made aware of written allegations of abuse which were presented to the Board. These allegations were not reported to the Director, further the results of the investigation were not reported to the Director. The former Administrator/Director of Care had resigned thus the inspector was unable to interview her related to the outcome, if any, of the investigation. The licensee failed to ensure that the results of the investigation are reported to the Director. [s. 23. (2)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. Inspector reviewed three written complaints provided to the Board on March 20, 2013. One of the written complaints contains allegations of abuse. These allegations of abuse were never reported to the Director. The licensee failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident immediately reports the suspicion and the information upon which it is based to the Director. [s. 24. (1)]

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

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THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS			
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. 70. (1)	CO #901	2013_099188_0014	188
LTCHA, 2007 S.O. 2007, c.8 s. 71. (1)	CO #902	2013_099188_0014	188

Issued on this 29th day of May, 2013

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