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
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 21, 2014	2013_140158_0042	S-0396,S-0397,	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

KELLY-JEAN SCHIENBEIN (158)

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): December 16-19, 2013

Log #: S-000396-13, S-000397-13, S-000467-13 and S-000441-13 were reviewed during this inspection.

During the course of the inspection, the inspector(s) spoke with spoke with Administrator, the Director of Care, the Food Service Supervisor, Registered Nursing Staff, Personal Support Workers, and residents.

During the course of the inspection, the inspector(s) conducted a walk through of various resident care areas, observed staff to resident interactions, reviewed health care records of residents and reviewed various policies and procedures within the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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.Resident # 05 was transferred to the hospital after falling in the home and sustaining injury. The Inspector reviewed resident # 05 health care record and a post fall assessment using a clinically appropriate assessment instrument, that is specifically designed for falls was not located. The licensee failed to ensure that when resident # 05 fell, a post-fall assessment was completed 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 that when a resident falls, a clinically appropriate assessment instrument that is specifically designed for falls is used in the post fall assessment, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. A critical incident was submitted to the Director seventeen days after a resident to resident physical abuse incident occurred, in which resident # 04 sustained abrasions, after being hit by resident # 03. The resident to resident physical abuse was not immediately reported to the Director.
The Inspector reviewed the home's abuse policy which identifies that incidents of resident to resident abuse shall be immediately reported to the Director.
The licensee did not ensure that its written abuse policy, specifically the reporting of resident to resident abuse was complied with, when the incident of resident to resident abuse occurred between resident # 03 and resident # 04. [s. 20. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. On December 18, 2013, the Inspector reviewed resident # 01 progress notes, which identified that there were two occasions when a specific action done by other residents, triggered resident # 01 physical aggression towards them. Resident # 01 plan of care was reviewed and although some behavioural triggers were identified, this specific action was not one of them. The licensee did not ensure that the behavioural triggers for resident # 01, who was demonstrating responsive behaviours was identified. [s. 53. (4) (a)]

Issued on this 21st day of January, 2014

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