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**

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## 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 |
|---|---|---|---|
| Jun 17, 2014 | 2014_283544_0014 | S-000190-14 | 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**

FRANCA MCMILLAN (544), KELLY-JEAN SCHIENBEIN (158), MARSHA RIVERS (576)

**Inspection Summary/Résumé de l'inspection**

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

**This inspection was conducted on the following date(s): May 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 2014 and was related to,**

**Log # S-000190-14**
**Log # S-000192-14**
**Log # S-000530-13**
**Log # S-000197-14**
**Log # S-000026-14**

**During the course of the inspection, the inspector(s) spoke with Administrator,**

**Interim Director of Care (Interim DOC), RAI/MDS Co-ordinator, Registered Staff (RNs, RPN.s), Personal Support Workers (PSWs), Physiotherapy Assistant (PTA), Activity Co-ordinator, Maintenance Supervisor, Maintenance Worker, Laundry Aides, Housekeeping Aides, Kitchen Manager, Dietary Aides, Residents and Families.**

**During the course of the inspection, the inspector(s) walked through the home daily, observed daily the care and service delivery to the residents and staff to resident interactions, observed housekeeping staff perform their duties, observed dining room meal services, observed three (3) medication passes to the residents and reviewed the following: resident health care records, care plans and kardexes, all the Housekeeping, Laundry and Maintenance services policies and procedures, the Continence Care and Bowel Management Program and staff education regarding the program, the Prevention of Abuse and Neglect Policy and the staff education regarding the policy, the Responsive Behaviours Program and the staff education regarding the program, the Personal Support Services Policies and procedures regarding foot care, nail care and bathing of residents, the Skin and Wound Care Program and the staff education regarding this program, the Infection Prevention and Control Program and the staff education regarding this program, the Hospitalization and Change in Condition Policy and staff duties regarding this policy, Minimizing of Restraints Policies and staff education regarding the policy, the Reporting and Complaints policy and staff education regarding the policy, the Falls Prevention Program and the staff education regarding the program, the Pain Management Program and the staff education regarding the program, the Medication Administration Policies and Procedures and staff education regarding this policy, the Resident Council meeting minutes, the Dietary policies regarding food temperatures, production sheets and the current menus, the Recreational and Social Activities policies and procedures and the Activity Calendars and the Home's Critical Incident Response procedure to the Director.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**
**Accommodation Services - Laundry**
**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Critical Incident Response**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Food Quality**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Pain**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Recreation and Social Activities**
**Reporting and Complaints**
**Residents' Council**
**Skin and Wound Care**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. Inspector # 576 observed that the wall-mounted computer monitor that is located in the main corridor of the home was unattended and displayed resident information including resident name, resident picture, diet information, and resident allergies. Staff # 100 was notified and witnessed the open screen and confirmed that a staff member did not log off the Point Click Care Program.

2. Inspector # 158 observed that Staff # 117 and Staff # 120 were providing toileting assistance to Resident # 4394. The Inspector observed that the resident's trousers were lowered and the resident was then transferred onto toilet. Privacy was not provided to resident # 4394

The licensee did not ensure that every resident's right to be afforded privacy in treatment and in caring for his or her personal needs was respected. [s. 3. (1) 8.]

***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 all residents are afforded privacy in treatment and in caring for their personal needs., to be implemented voluntarily.***

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**WN #2: 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).**

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**Findings/Faits saillants :**

1.Inspector # 544 observed that the chesterfield and arm chairs in one of the Lounges were soiled and stained. Staff # 100 and Staff # 109 confirmed that new furniture was on order for this area. Six (6) out of fifteen (15) dining room chairs were stained. The door of a Resident's room was stained with a liquid material. The bathroom floor in Zone 3 was sticky and was stained with a yellow fluid and the grouting between the tile was black. The bathroom floor, next to Room 1, was stained and had yellow fluid on the floor.
Inspector # 576 observed that the caulking in the shower room between Rooms 2 and 4 was black. The shared bathroom located in the hallway between two rooms had broken tiles. The hand sanitizer outside of Room # 30 was empty.

The licensee did not ensure that the home, furnishings and equipment were kept clean and sanitary. [s. 15. (2) (a)]

2. Inspector # 544 walked through the home daily and observed the following:
The hallway floor entering Zone 7, at the fire doors, was cracked and a piece of tile was missing. This part of the floor was uneven.
The hallway floor entering Zone # 5, at the fire doors, was cracked and the floor was uneven.
The shared bathroom located in the hallway between rooms 9 and 11 had broken tiles.
The bottom of the resident room doors were scuffed. Staff # 109 confirmed that there are plans to place an arbourite material approximately 8-12 inches high on the bottom of the doors to alleviate this scuffing from wheelchairs and walkers.
In Room # 29, the closet was scuffed. In Room # 12, the resident's dresser was chipped on the top of the dresser and chipped at the bottom and the third handle on the drawer was broken.
The washroom near Room # 1 had grout missing on the floor tiles and around the toilet bowl there was missing caulking and the area was black.
The bathroom floor in Zone 3, was cracked.
Inspector # 158 identified that the tub room near Room 30 had chipped tiled floors and built up residue on the surfaces
The shower room near Room # 30 had sealant caulking missing in some areas and the caulking that was present was black in colour on some surfaces. The plastic dome roof above the shower had a build up of debris and dust.

The licensee did not ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

***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 home, furnishings and equipment are kept clean and sanitary and are maintained in a safe condition and in a good state of repair., to be implemented voluntarily.***

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**WN #3: 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).**

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**Findings/Faits saillants :**

1. Inspector # 158 reviewed a Critical Incident report.

Resident # 4387, sustained a laceration to their face after being struck with a metal travel mug by Resident # 5109. Resident # 4387 was transferred to hospital and returned to the home with sutures in place.

The home’s abuse policy states that incidents of resident physical abuse, which cause physical injury/pain, are reported to the Director immediately. The policy also states that “the health care team will review the perpetrator’s care plan, review interventions to deal with the abusive or aggressive behaviour and update the care plan." The policy identified that the resident’s need for a referral to a specialist (Seniors’ Mental Health, Behavioural Support Ontario) be assessed.
The incident was reported to the Director however, it was reported as an Incident that caused injury and not as a resident to resident physical abuse incident, which must be immediately reported to the Director.

2. Another incident occurred when resident # 5109 hit Resident # 4381, using a metal eating utensil. No injury occurred in this incident.

Resident # 5109's health care record was reviewed by Inspector # 158. Although, resident # 5109's care plan identified the resident's anger and and aggressive behaviour, the plan did not identify Resident # 5109's physical aggression using metal utensils and subsequent interventions to prevent further aggressive incidents.
Staff # 118, # 105 and # 104 stated to Inspector # 158, that Resident # 5109 had been assessed by Senior's Mental health in 2013. The three staff stated that there has been no discussion related to referring resident # 5109 again to Senior's Mental Health or Behavioural Support Ontario.

The home did not ensure that the home’s written policy that promotes zero tolerance of abuse and neglect of residents was complied with, specifically related to reporting abuse to the Director, updating Resident # 5109's care plan and assessing whether Resident # 5109 required a referral to a specialist. [s. 20. (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 home's policy, that promotes zero tolerance of abuse and neglect of the residents, is complied with., to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping**

**Specifically failed to comply with the following:**

**s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,**
**(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).**

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**Findings/Faits saillants :**

1. Inspector # 544 interviewed Staff # 109 who confirmed that managing odours in the home is an issue.
Inspector identified that smoking is allowed in the entrance of the building and the smell of smoke permeates throughout the building. The Inspector, other residents sitting in the lobby area, families and visitors could smell the smoke odour. Inspector observed daily that 7-8 residents were smoking in this area most of the day.
There is a plan to have a smoking shelter built away from the entrance of the home and place it at the rear of the building. There is no date when this might occur.

2. Inspector noted a strong odour of urine throughout the building especially in 3 specific zones. Staff # 109 confirmed that there are three (3) automizers throughout the building and HEX-ON concentrated sprays but, they are not sufficient to eliminate the lingering offensive odours. The odours were lingering daily during the inspection and for many hours throughout the day. Staff # 109 also confirmed that the home is looking for quotes from ventilation (HVAC) companies to provide the home with air exchangers or a ventilation system to control the odours.

The licensee did not ensure that procedures are yet developed and implemented for addressing incidents of lingering offensive odours. [s. 87. (2) (d)]

***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 developed and implemented to address incidents of lingering offensive odours., to be implemented voluntarily.***

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**WN #5: 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):**
**2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,**
**i. a breakdown or failure of the security system,**
**ii. a breakdown of major equipment or a system in the home,**
**iii. a loss of essential services, or**
**iv. flooding.**
**O. Reg. 79/10, s. 107 (3).**

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**Findings/Faits saillants :**

1. Inspector # 544 reviewed a Critical Incident report.

Resident # 001 had a witnessed fall in their room that resulted in a significant injury and change in their condition. As a result, the Resident was transferred to hospital. It was not reported to the Director no later than one business day of the occurrence of the incident.

The licensee failed to inform the Director no later than one business day after the occurrence of the incident of:
Subject to subsection (3.1), an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital. [s. 107. (3)]

2. Inspector # 544 reviewed another Critical Incident report that was reported to the Director.

Staff # 107, reported to the Director of Care, that a (controlled substance), narcotic was unaccounted for.
The police were notified of the incident. Staff # 107 and the other agency Registered Staff were interviewed by the police.
Inspector interviewed Staff # 107 who confirmed that, the Registered Staff were not counting the controlled drugs at the end of each shift but signing off on the drug count sheet as completed.

The licensee failed to inform the Director, no later than one business day after the occurrence of the incident, of a missing or unaccounted for controlled substance. [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 to ensure that the Director is informed no later than one business day after the occurrence of an incident that results in a transfer to hospital and a significant change in the residents' condition and in reporting missing controlled substances., to be implemented voluntarily.***

**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,**
**(a) infectious diseases; O. Reg. 79/10, s. 229 (3).**
**(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).**
**(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).**
**(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).**
**(e) outbreak management. O. Reg. 79/10, s. 229 (3).**

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:**
**1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).**

**Findings/Faits saillants :**

1. Staff # 115 has recently taken on the role of the Infection Control Practitioner. Inspector # 158 reviewed Staff # 115 personnel files and did not find any educational certificates or supporting documentation that showed the staff member had the extra required education and experience in infection prevention and control practices. In discussion with the Staff # 100 and Staff # 101, it was identified that Staff # 115 had taken some courses in infection control but were unable to state the course titles or produce documentation to support this.

The home did not ensure that the designated staff member, who co-ordinates the infection prevention and control program has education and experience in infection prevention and control practices, which includes; infectious disease, cleaning and disinfection, data collection and trend analysis, reporting protocols and outbreak management. [s. 229. (3)]

2. Inspector # 544 observed Staff #114 administering medication and observed that,

during the medication pass, the staff member was not washing their hands or sanitizing their hands between residents after administering their medications. Inspector noted that Staff # 114 did sanitize their hands after the third resident was administered medications. Inspector also noted that Staff # 114 did not sanitize or wash their hands before or after administering eye drops to Resident # 4393 in the dining room.

Inspector again observed Staff # 114 administering medication to residents and again did not wash or sanitize their hands between residents. The bottle of sanitizer was on the right side of the cart in an open bin.

3. Inspector # 544 observed Staff # 105 administering medication and observed that this staff member did not wash their hands or sanitize their hands between administering medication to residents. Inspector also observed Staff # 105 with gloves on their hands. Staff # 105 removed the gloves upon returning to the medication cart and did not wash or sanitize their hands after removing the gloves.
Inspector # 544 again observed Staff # 105 administering medication and again noted that the staff member did not wash or sanitize their hands between residents.

Inspector # 544 reviewed the Infection Prevention and Control Manual dated August 2013 Section 8.0, Subsection 8.1 Hand Hygiene which states, "Hands should be washed between direct contact with individual residents, between care activities involving the same resident and after removing gloves."
The licensee did not ensure that all staff participate in the implementation of the Infection Prevention and Control Program. [s. 229. (4)]

Inspector # 158 reviewed the home's policy regarding immunization and it states that, "all residents will receive a 2-step Mantoux within 14 days of admission unless there are documented results within the last year. The second step is completed 7 to 21 days after the 1st. If the first step test is positive, an x-ray is then ordered by the physician." Staff # 104 stated to the Inspector that, when a resident is admitted, the CCAC records are used to determine the resident's history and that the resident's immunization status is inputted into the computer ,as well as, in the resident's health care record.

4. Inspector # 158 reviewed resident # 4565 health care record. The form (Treatment Consent for Administration of Influenza, Pneumococcal Vaccines, Amantadine and Two-Step Mantoux ) was unsigned by the "health practitioner" and "unknown" was

written beside the questions related to the Two-Step Mantoux . The Inspector did not find any documentation in Point Click Care or in their progress notes identifying that the resident was screened for Tuberculosis.

5. Inspector # 158 reviewed resident # 7401's health care record. The consent form (Treatment Consent for Administration of Influenza, Pneumococcal Vaccines, Amantadine and Two-Step Mantoux ) was completed and indicated that the resident had not received a Mantoux skin test within the last year. The two-step Mantoux was not signed as completed on the Resident Admission Checklist. The Inspector did not find any documentation in Point Click Care or in the progress notes identifying that the resident was screened for Tuberculosis.

6. Inspector # 158 reviewed resident # 3406's health care record. The consent form was not found on the resident's chart. A note was posted to the blank Resident Admission Checklist for the physician to assess the resident with regards to Resident # 3406's immunization status, including the TB screening. The Inspector did not find any documentation in Point Click Care or in Resident # 3406's progress notes identifying that the resident was screened for Tuberculosis.

The licensee failed to screen 3/3 residents for Tuberculosis within 14 days of their admission as directed by the home's policy. The licensee did not ensure that each resident admitted to the home was screened for tuberculosis within 14 days of admission, unless the resident had already been screened at some time in the 90 days prior to admission and the documented results of this screening were available to the licensee. [s. 229. (10) 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 each Resident admitted to the home is screened for Tuberculosis within 14 days of admission unless the Resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee., to be implemented voluntarily.***

**WN #7: 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).**

**Findings/Faits saillants :**

1. Inspector # 576 observed Resident # 4351 several days during the inspection and found that resident's hair was unclean. In reviewing the health care records for Resident # 4351, Inspector noted that between a period of time, the resident refused a shower 4/10 scheduled bath days. The care plan does not identify the behaviour of refusing to shower and does not provide direction to staff when this resident refused to shower. Staff # 118 confirmed that the care plan for Resident # 4351 does not provide interventions when the resident refused to shower. Inspector noted that in the kardex under bathing, it states that the resident "prefers a shower every Tuesday and Friday." In the same kardex under hygiene and grooming, it states that the "preferred bath days are Monday and Thursday on day shift." Staff # 118 confirmed that the PSWs refer to the kardex for information on the plan of care and that the kardex for Resident # 4351 does not provide clear direction to staff with respect to preferred bath days.

2. Inspector # 576 reviewed health care records for Resident # 4394. It is documented in Point Click Care that this resident has upper dentures and natural lower teeth. The care plan identifies that this resident requires extensive assistance of one staff for oral care in the morning and evening, but does not provide direction to staff about the nature of the oral care required. It is documented in Point of Care that oral care, including mouthcare, brushing teeth, brushing dentures, and inserting and removing dentures, was provided to this resident twice daily. Staff # 113 confirmed that PSWs document the provision of care in Point Click Care. Staff # 117 and Staff # 113 confirmed that, Resident # 4394 does not wear any dentures and oral care provided to this resident includes cleaning the resident's mouth with toothette swabs and mouthwash.
The plan of care for Resident # 4394 does not set our clear directions to staff with respect to oral care.

The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

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**WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.**

**Specifically failed to comply with the following:**

**s. 29. (1) Every licensee of a long-term care home,**
**(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).**
**(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).**

**Findings/Faits saillants :**

The home's restraint policy states that "an order for the use of a restraint is to be obtained from the physician and that consent is to be obtained from the resident or substitute decision maker". The policy further identifies that documentation of the application of the restraint, the release of the restraint and the resident's response, is documented by the PSW.

1. Resident #4394's was ordered a seat belt restraint. The physician changed the seat belt restraint order to a lap restraint when Resident # 4394 is sitting in their wheelchair. When the family did not approve of the lap restraint, the physician discontinued Resident # 4394's lap restraint and ordered a seat belt for safety, to be buckled at the back. Inspector # 576 observed that a seat belt was applied, when the resident was sitting in their wheelchair and it was buckled at the back. A current consent for the restraint was not found in Resident # 4394's health care record.
A restraint use assessment was completed which identified that a rear buckled seat belt was required for Resident # 4394's safety.
The registered staff were documenting in Resident # 4394's treatment administration record, that the seat belt restraint was assessed every shift, however, the PSWs were not documenting the application of the restraint, the release of the restraint or the resident's response.
The home's policy identifies that the effectiveness of the restraint use will be evaluated.
A quarterly MDS assessment was completed related to Resident # 4394's restraint use. An evaluation of the seat belt restraint use or the effectiveness of this care intervention was not documented.

The home failed to ensure that the home's restraint policy was complied with in regards to Resident # 4394's restraint use.

2. Resident # 4368 was observed by Inspector # 544 in bed with both rails up one afternoon. Inspector # 158 observed that the resident was sitting in their wheelchair on

another afternoon with a lap seat belt restraint (front facing) applied. It was confirmed by Staff # 108, that the resident is unable to undo the restraint and is unable to get out of bed on their own.
MDS quarterly assessments completed by Staff # 121 identified that Resident # 4368 requires the use of 2 full bed rails when in bed and a seat belt fastened at the front when sitting in their wheelchair.
Resident # 4368's health care record was reviewed by Inspector # 158. A consent for the use of side rails was not found. A consent for the lap restraint was found. The informed consent bullet was ticked off on the MDS assessment, however, there was no documentation found to support who consented and when the consent was obtained.
Inspector # 158 reviewed Resident # 4368's flow sheets which showed that the PSWs were documenting the application of the lap seat belt restraint, the release of the restraint and the resident's response but were not documenting the use of the bed rail restraint.
The home's policy identifies that the effectiveness of the restraint use will be evaluated. The MDS assessments were reviewed and an evaluation of the restraint use was not identified. The use of the restraints (2 full rails in bed and a lap restraint when up in chair) were identified in resident # 4368 annual MDS assessment but the evaluation or effectiveness of the restraint use was not completed.

The home failed to ensure that the home's restraint policy was complied with in regards to resident # 4368's restraint use.

3. Inspector # 158 observed that Resident # 4351 was sitting in his wheelchair with a seat belt restraint (front facing) applied. It was confirmed by Staff # 108, that the resident was unable to unbuckle the restraint.
The restraint assessments which were completed by Staff # 121 and identified that the use of a seat belt restraint (front facing) was required to keep Resident # 4351 safe when he is sitting in his wheelchair.
Inspector # 158 reviewed Resident # 4351's health care record. Consent for the use of a seat belt restraint was not found. The informed consent bullet was ticked off on the MDS restraint assessment however, there was no documentation found to support who consented and when the consent was obtained for the restraint.

The home failed to ensure that the home's restraint policy was complied with in regards to Resident # 4351's restraint use. [s. 29. (1) (b)]

**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care**

**Specifically failed to comply with the following:**

**s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).**

**s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).**

**Findings/Faits saillants :**

1. Inspector # 576 reviewed health care records for Resident # 4351. In the care plan, for this resident, it stated that registered staff is to trim toenails on the first bath day of the month and as needed. Progress notes for a period of time identified that this resident's toenails were cleaned, trimmed and filed once during this period of time by Staff # 118. This was also confirmed by Staff # 118. Staff # 118 and Staff # 100 identified that the home's policy is that only qualified registered staff provide foot care to high risk resident. Staff # 118 is the only staff member in the home that is qualified to provide foot care to high risk residents, including residents with diabetes and residents on the drug Coumadin. Staff #118 and Staff # 100 stated that as of earlier in the year, the home no longer provides allocated time for Staff # 118 to provide foot care services. Staff # 118 confirmed that there is no time in their work day to provide foot care to all high risk residents and that basic foot care has not been provided to most of the high risk residents.

The licensee failed to ensure that each resident of the home receives preventative and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. [s. 35. (1)]

2. Inspector # 576 observed Resident # 4351 to have long unclean fingernails. Inspector # 576 reviewed the health care records and identified the the Resident was high risk due to their diagnosis. The care plan states that PSWs are to clean the nails and registered staff are to trim and file nails on bath days. It is documented in Point of Care that the nails were not cleaned or trimmed on any of the ten scheduled bath

days for this Resident. Progress notes for an extended period of time, identify that this resident's fingernails were cleaned, trimmed and filed only once by Staff # 118. This was confirmed by Staff # 118. Staff # 113 stated that PSWs document provision of care, including fingernail care, in Point of Care and that PSWs clean resident fingernails but do not trim this resident's fingernails. PSWs have been instructed not to trim fingernails of residents who have diabetes or who are on the drug Coumadin. This is confirmed by Staff # 118.

3. Inspector # 576 observed Resident # 4394 to have long unclean fingernails. Inspector reviewed health care records and identified that this resident is on the prescribed Coumadin. With respect to fingernail care, the kardex states that PSWs are to clean and trim nails on bath days. Staff # 113 stated that PSWs clean this resident's fingernails only due to being on Coumadin and at high risk for injury or infections. Staff # 118 confirmed Resident # 4351 is prescribed the drug Coumadin and that the home's policy is that, only qualified registered staff trim fingernails of high risk residents. Staff # 118 and the Staff # 100 stated that recently, the home no longer provides allocated time for Staff # 118 to provide nail care. Nail care is only provided as needed by Staff # 118. It is confirmed by Staff # 118 that there is no time in their regular work day to trim fingernails of most high risk residents, including resident 4394.

The home failed to ensure that each resident of the home receives fingernail care, including the cutting of fingernails. [s. 35. (2)]

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**WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council**

**Specifically failed to comply with the following:**

**s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).**

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**Findings/Faits saillants :**

1. Inspector # 576 reviewed records maintained by the Resident's Council for a one year period and noted that in the meeting minutes, the Resident Council identified concerns and recommendations, including issues regarding food quality, meal service, resident privacy during care, wandering residents, and missing clothing items. Staff # 116, who is the appointed Residents' Council assistant, stated that concerns and recommendations identified by the Council are brought forward by the Residents' Council assistant to the relevant personnel and the results of these discussions are reported back to the Council. Staff # 116 and Staff # 100 confirmed that the home does not respond in writing to the concerns or recommendations identified by the Residents' Council.

The licensee failed to ensure that a written response is provided within 10 days of receiving Residents' Council advice related to concerns or recommendations. [s. 57. (2)]

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**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production**

**Specifically failed to comply with the following:**

**s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,**
**(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).**

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**Findings/Faits saillants :**

1. Inspector # 576 observed a lunch dining service. Point of service temperatures for all hot and cold food items were taken by Staff # 119 at the request of the Inspector. At this meal service, point of service temperatures for cold food items ranged from 40 degrees Fahrenheit to 55 degrees Fahrenheit. Inspector reviewed food temperature records for several days and noted that the holding temperatures for all cold food items served during this period exceeded 40 degrees Fahrenheit, and ranged from 45 degrees Fahrenheit to 65 degrees Fahrenheit. The home's policy for serving hot and cold food items "Breakfast / Lunch / Supper Protocol" states that cold food items are to be held at or below 40 degrees Fahrenheit and identifies the food danger zone to be 41 degrees Fahrenheit to 135 degrees Fahrenheit. Staff # 103, confirmed that prepared cold food items were stored at temperatures that exceeded 40 degrees Fahrenheit and were stored at temperatures that the home identified to be in the food danger zone.

The licensee failed to ensure that prepared cold food items are stored using methods which preserve food quality. [s. 72. (3) (a)]

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**WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey**

**Specifically failed to comply with the following:**

**s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).**

**s. 85. (4) The licensee shall ensure that,**
**(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).**
**(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).**
**(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).**
**(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).**

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**Findings/Faits saillants :**

1. Inspector # 576 reviewed minutes of Residents' Council for a period of one year. Inspector noted that in the minutes for a meeting held, it is recorded that Staff # 116, who is the appointed Residents' Council assistant, showed the residents, the Wikwemikong Nursing Home Customer Satisfaction Surveys that will be delivered to residents or their family members. Staff # 100 confirmed that the Resident Satisfaction Survey was completed in 2013. There was no indication in the meeting minutes that the home sought the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results. Staff # 100 and Staff # 116 confirmed that the home did not seek the advice of the Resident's Council in developing and carrying out the satisfaction survey, and in acting on the results.

The licensee failed to seek the advice of the Residents' Council in developing and carrying out the survey and in acting on the results. [s. 85. (3)]

Inspector # 576 reviewed minutes of Residents' Council meetings for the year. Inspector noted that there was no indication in the meeting minutes that the home discussed the results of the 2013 satisfaction survey with the Residents' Council. Staff # 100 confirmed that the Resident Satisfaction Survey was completed in 2013. Staff # 100 also confirmed that the results of the survey were shared with the staff, but did not share the results with the Residents' Council. The home did not seek the advice of the Resident Council in acting on the survey results.

The licensee failed to ensure the results of the survey are documented and made available to the Residents' Council and to seek their advice in developing and carrying out the survey and in acting on the results. [s. 85. (4) (a)]

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**WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service**

**Specifically failed to comply with the following:**

**s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,**
**(a) procedures are developed and implemented to ensure that,**
**(i) residents' linens are changed at least once a week and more often as needed,**
**(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,**
**(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and**
**(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).**

**Findings/Faits saillants :**

1.Inspector # 544 interviewed Laundry Aide Staff # 110 and identified that the residents' clothing is not being labelled within 48 hours of acquiring new clothing and is not being labelled within 48 hours of a resident's admission.
Staff # 110 confirmed, that the laundry department is to wait until there is a "pile" of clothing and then they are to be all labelled at one time.
Staff # 109 confirmed that this is the direction given to the laundry staff on labelling residents' clothing.
Staff # 100 confirmed that this is the present practice and with the laundry department, a schedule will be developed whereby the residents' clothing will be labelled within 24-48 hours of admission of a Resident or of a Resident acquiring new clothing.

The licensee did not ensure that the residents' personal items and clothing are labelled within 48 hours of admission and of acquiring new clothing. [s. 89. (1) (a) (ii)]

**WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services**

**Specifically failed to comply with the following:**

**s. 90. (3) The licensee shall ensure that the home's mechanical ventilation systems are functioning at all times except when the home is operating on power from an emergency generator. O. Reg. 79/10, s. 90 (3).**

**Findings/Faits saillants :**

1. Inspector did a walk through the home daily and did not note any fans, air exchangers or system for ventilation in the home.
Inspector # 544 interviewed Staff # 100, Staff # 109, and Staff # 112, who all confirmed that there is no ventilation system in the building.
Staff # 100, # 109 and # 112 also confirmed that a tender process has been initiated to companies for quotes to have a ventilation system installed in the home. Some pricing quotes have been returned and the licensee is awaiting more pricing for comparison.

The licensee has not ensured that there is a mechanical ventilation system functioning at all times. [s. 90. (3)]

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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)<br>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** |
| O.Reg 79/10 s. 48. (1) | CO #001 | 2013_140158_0041 | 158 |

**Issued on this 18th day of June, 2014**

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