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 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 15, 2015	2015_283544_0002	004872-15	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

FRANCA MCMILLAN (544)

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): September 14, 15, 16, 2015 and included a number of Minstry logs.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Staff, Personal Support Workers (PSWs), maintenance and office staff, Residents and Families.

The inspector also toured the home daily, observed staff to residents interactions, staff providing care and services to residents, residents who were exhibiting responsive behaviours and staff interventions, reviewed residents' health care records, care plans, policies and procedures regarding Prevention of Abuse and Neglect, Falls Prevention and Management Program, Responsive Behaviours Program and other pertinent records.

For other non-compliance related to the Critical Incidents, please refer to the Follow up inspection report 2015_283544_0023.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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	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. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour program was implemented in accordance with evidence- based practices for resident # 020.

Inspector reviewed a Critical Incident related to an alleged resident to resident abuse.

Staff witnessed resident # 020 exhibit aggressive responsive behaviours toward resident # 001. This was the first time resident # 020 exhibited aggressive responsive behaviours and first altercation with a resident. Resident # 001 was not injured.

The Critical Incident report stated that the home would initiate Dementia Observation System (DOS) documentation and would revise resident # 020's care plan. Resident # 020 was also to be referred to Behavioural Support Ontario (BSO).

Inspector reviewed the home's Responsive Behaviour Program, Subsection 13.1 Behavioural Support: Revised September 13, 2015. It identified that DOS documentation would be initiated, after a resident had exhibited responsive behaviours. This documentation was to be conducted for 72 hours. The resident's care plan was to be revised and a referral would be sent to Behavioural Support Ontario, (BSO).

Inspector reviewed resident # 020's health care record and identified that the Dementia Observation System (DOS) documentation was incomplete and was not conducted for the full 72 hours as per the home's Responsive Behaviour policy. An assessment by BSO had not been completed and the home did not follow up on the referral.

A review of the care plan, by the inspector, identified that the care plan was not revised after this incident. The care plan did not identify the focus, goals or interventions for resident # 020's responsive behaviours.

Inspector interviewed Administrator # 102 and Director of Care (DOC) # 111 who confirmed the above findings. Administrator #102 and DOC #111 told the inspector that the expectation is that the staff follow up and complete the necessary documentation required to manage resident # 020's responsive behaviours.

Inspector's observations, made throughout the day revealed that resident # 020 exhibited signs of aggressive responsive behaviours through their verbal interactions with staff and other residents who bothered them. [s. 53. (3) (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 to ensure that the responsive behaviour program will be implemented in accordance with evidence- based practices for resident # 020, to be implemented voluntarily.

WN #2: 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 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).
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. The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of the incident of a missing or unaccounted for controlled substance.

Inspector reviewed a Critical Incident related to a missing controlled medication. RPN # 110 documented that the pain patch was not on resident # 001's body where it had been applied, when they went to put on a new patch. After an investigation, RN # 111, RPN # 107 and RPN #104 were unable to determine if it had fallen off or if resident # 001 pulled it off.

Inspector reviewed resident # 001's health care record. The progress notes identified that for three days in a month, RN # 101 and RN # 117 could not find the pain patch on resident # 001's body to be removed, to add a new one.

This happened again and a second investigation was conducted by the home and they were not able to determine who, how or when the patches were removed from resident # 001's body as confirmed by DOC # 111, RPN # 104 and RPN # 107.

DOC # 111 reported these incidents to the Administrator # 102 on July 27, 2015. A Critical Incident report was submitted to the Director on July 30, 2015.

2. The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of the incident of a missing or unaccounted for controlled substance.

Inspector reviewed a Critical Incident related to one controlled medication tablet that was missing.

The medication pouch appeared to be tampered with and granules of the controlled medication were found throughout the pouch. Outgoing RPN # 115 and incoming RN # 116, failed to check through the full card at the beginning of the shift to ensure that the medication card was complete, as confirmed by Administrator # 102, DOC # 111 and RN #114

This incident occurred on October 12, 2014. The home reported the Critical Incident, to the Director, on October 15, 2014. [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 of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection(4): 3. A missing or unaccounted for controlled substance, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policies and protocols were developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Inspector reviewed a Critical Incident regarding a missing pain patch from resident 001's body when staff were applying a new one.

Resident # 001 was ordered a pain patch for their pain management. RN # 101 documented that the pain patch was not on resident # 001's body where it was normally situated. After an investigation, RN # 101 and RN # 117 were unable to determine if the pain patch had fallen off or if resident # 001 pulled it off.

Resident # 001's pain patch was not on resident # 001's body where it was normally

situated a second time. A second investigation was conducted by the home and they were unable to determine, who, when and how the pain patch had been removed from resident # 001's body.

Inspector reviewed Medical Pharmacies Pharmacy Policy and Procedure Manual for LTC Homes dated January 2014, Section 6 Policy 6-6, "Shift Change Monitored Drug Count." The policy stated: " Shift Change Monitoring Medication Record," and confirm the actual is the same amount as the amount recorded on the Individual Monitored Medication Record." "This shift count is a means to regularly audit the monitored medication for accuracy. Report any discrepancies to the Director of Care (or delegate) immediately." "A monthly audit of the shift count by the DOC or delegate compared to the quantity of medication remaining (and individual counts if used), is a requirement of the LTCH Act."

There was no documentation to identify that a monthly audit had been completed for the accuracy and any discrepancies for the missing controlled medications as confirmed by Administrator # 102, RPN # 104, DOC # 111 and RPN # 107.

2. Inspector reviewed a Critical Incident regarding a missing controlled medication.

Resident # 023 was prescribed a controlled medication for their pain management.

RPN # 104 and RN # 117 conducted a controlled medication count. One controlled medication tablet was missing from slot # 10 of a 30 slot card. RPN # 104 and RN # 117 could not find the missing controlled medication. Administrator # 102 and Acting DOC # 101, called the police and the pharmacy service provider was notified. They were not able to determine when the medication tablet was actually missing.

An investigation was conducted by the home and 7/9 Registered Staff were interviewed. They were staff members who had access to the medication room and in possession of the narcotic cupboard key for a four day period.

In an interview, Administrator # 102 and DOC # 111 told the inspector that several staff members told them that they do not always look at the slots in the card nor pull out the card fully to ensure the number of tablets in the card was the same as the narcotic count sheet as per the home's policy. They also confirmed that the incoming staff member and outgoing staff member did not always conduct the change of shift count of the narcotics as per the home's policy, Policy 6-6, Shift Change Monitored Drug Count."

As well, there was no documentation to identify that a monthly audit was conducted for the accuracy of the number of medications in these narcotic medication cards or for any discrepancies of the narcotic medication cards as identified in the home's policy.

Administrator # 102 and DOC # 111 confirmed that monthly audits were not completed as per the home's policy regarding controlled medications.

3. Inspector reviewed a Critical Incident regarding a missing controlled medication. Resident # 022 was prescribed a controlled medication for their pain management.

Staff identified one missing controlled medication tablet from the strip # 3 at the change of shift. The pouch appeared to be tampered with and granules of the medication were found throughout the pouch. Outgoing RPN # 115 and incoming RN # 116, failed to check through the full strip at the beginning of the shift to ensure that the medication card was complete and intact.

In an interview with Administrator # 102 and DOC # 111, they told the inspector that several staff members told them that they do not always look at the slots in the card nor pull out the card fully to ensure the amount of tablets in the card was the same as the narcotic count sheet.

Administrator # 102, RPN # 104, RPN # 107, DOC #111, RN #112, and RN #114 confirmed that the narcotic count was not always performed at the end of each shift by 2 registered staff as required by the home's policy.

Inspector reviewed the end of shift narcotic count sheets and identified that 2 registered staff initials were not always documented at the end of each shift. Some registered staff initials were missing and the narcotic count form was incomplete.

There was no documentation that identified a monthly audit was conducted for accuracy of the narcotic medication cards count and for any discrepancies regarding the number of controlled medications remaining in the cards as confirmed by Administrator # 102, DOC # 111, RPN # 104, and RN # 114. [s. 114. (3) (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 to ensure that the written policies and protocols related to the home's medication management are implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a Registered Dietitian who is a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Inspector reviewed three (3) critical incidents reported to the Director regarding missing controlled medications.

Inspector interviewed Administrator #102, RPN # 104 and DOC # 111 who told the inspector that the new Director of Care, who was recently hired, implemented new procedures regarding controlled medications. These new procedures were implemented to ensure that missing controlled medications would not reoccur and that accurate numbers of the controlled medications were correct each and every shift. Discrepancies were to be noted and reported immediately to the DOC or Administrator. All registered staff were being educated on these new procedures. There was no documentation to support that an interdisciplinary team met annually, over the last few years, to evaluate the effectiveness of the medication management system and recommend any necessary changes to improve the system and this was confirmed by Administrator # 102 and DOC # 111.

Administrator # 102 confirmed to the inspector that the home did not have a permanent Director of Care (DOC), until recently.

Inspector reviewed the home's Medical Pharmacies Medication Policy and there was no documentation to support that the policy was updated to reflect the changes implemented by the new DOC. Upon further review, the Medical Pharmacies Policy and Procedure Manual for LTC Homes Section 6:6 identified that the policy was last updated in January 2014. [s. 116. (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 an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a Registered Dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, to be implemented voluntarily.

Issued on this 16th day of December, 2015

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

Original report signed by the inspector.