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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 12, 2017	2017_615638_0016	021449-17	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

RYAN GOODMURPHY (638)

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 5 - 8, and 13 - 14, 2017.

The following intakes were inspected in this Critical Incident System (CIS) inspection;
-One log was related to a critical incident the home submitted to the Director regarding a suspected incident of resident to resident abuse, and
-One log was related to a trend identified regarding missing narcotics.

A Follow Up inspection #2017_615638_0017, and a Complaint inspection #2017_615638_0018, were conducted concurrently with this CIS inspection. Findings of non compliance identified during this CIS inspection related to s. 24 (1), reporting certain matters to the Director and s. 19 (1), duty to protect residents from abuse have been included within Follow Up inspection #2017_615638_0017.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Maintenance Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping staff and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant internal investigation notes, licensee policies, procedures, programs and resident health care records.

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

During the course of this inspection, Non-Compliances were issued.

2 WN(s)
2 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

A CIS report was submitted to the Director related to an incident of suspected resident to resident abuse.

Inspector #638 reviewed resident #001's health care records and identified within their plan of care that at the time of inspection the resident had a specific intervention implemented to monitor the resident, which was initiated the morning after the incident had occurred in August 2017.

The Inspector reviewed the documentation regarding the specific intervention implemented to monitor resident #001 over an eight day period. The Inspector identified that there were gaps in the documentation record on three of the eight days. On the first date, the Inspector identified 15 occasions in which there was no documentation related to the resident's specific intervention. There was no documentation regarding the resident's specific intervention for seven hours for the resident on the second date and no documentation on the specific intervention for two hours and fifteen minutes on the third date.

In an interview with Inspector #638, PSW #103 indicated that when a resident was on this specific intervention, they were required to check and document the resident's status at specific times throughout the shift. The PSW reviewed resident #001's documentation regarding the specific intervention implemented to monitor the resident with the Inspector and stated that the results should have been documented when completed.

During an interview with Inspector #638, RN #104 stated that whenever a resident required the aforementioned intervention, direct care staff were required to complete all monitoring and document when completed. After reviewing resident #001's documentation record for their specific intervention, they indicated that there should not be any missing documentation regarding the checks.

In an interview with Inspector #638, the DOC indicated that each of resident #001's checks should have been documented in order to give a clear picture of the resident's status during the review period. [s. 6. (9) 1.]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

A CIS report was submitted to the Director related to an incident of suspected resident to resident abuse.

During an observation of resident #001's room, Inspector #638 noted a specific intervention implemented in the resident's room.

Inspector #638 reviewed resident #001's health care records and identified in a progress note written by RPN #102 on a specific date in August, 2017, that the resident demonstrated specific responsive behaviours when other residents entered their room. The notation indicated that a specific intervention was implemented as a result. The Inspector reviewed resident #001's care plan and was unable to identify any indication that the resident required this specific intervention to minimize their risk of behaviours.

In an interview with Inspector #638, PSW #101 stated that direct care staff should refer to the resident's care plan for interventions related to their needs. The PSW indicated that resident #001 had this specific intervention implemented for resident safety and they would expect this to be included in their care plan.

During an interview with Inspector #638, RPN #102 indicated that resident #001 had demonstrated agitation when other residents entered their room and had implemented a specific intervention during their shift to minimize risk of escalation. The RPN stated that any new intervention should be updated in the care plan by the registered staff initiating the intervention. The Inspector reviewed resident #001's care plan with RPN #102 who stated that the specific intervention had not been included in the resident's care plan and should be included.

In an interview with Inspector #638, the DOC indicated that direct care staff refer to the resident's kardex which was created from the care plan in Point Click Care (PCC). The DOC stated that any new intervention should be included in the care plan by registered staff to keep direct care staff aware of resident needs to ensure safety. They indicated that resident #001's care plan should have been updated to include the specific intervention due to their history of specific responsive behaviours. [s. 6. (10) (b)]

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 resident #001 and any other resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or the care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knew of, or was reported to the licensee was immediately investigated.

A CIS report was submitted to the Director, which detailed an incident of witnessed verbal and emotional abuse towards resident #002 in August 2017. The incident identified that at a specific time on a specific date in August 2017, the Administrator overheard RN #107 slam the nursing station door on resident #002 and stated "leave me alone" and "I can't tolerate (resident #002)".

Inspector #638 reviewed the internal investigation notes provided by the DOC, which identified that RN #107 was only interviewed regarding the incident of witnessed abuse by the Administrator seven days after the incident.

The Inspector reviewed the home's schedule and identified that RN #107 worked in the home as a registered staff member after the witnessed incident of abuse on two separate dates. The RN worked two full shifts prior to the home's investigation and the staff member's suspension.

In an interview with Inspector #638, the DOC indicated that whenever a staff member was suspected of abuse they would be put on a leave pending investigation and the investigation would commence immediately. The DOC indicated that they had

interviewed RN #107 regarding another incident two days after the incident had occurred, however, they did not discuss the witnessed incident of abuse by the Administrator two days prior, as the DOC believed that because the Administrator witnessed the incident that they had completed the investigation. The DOC indicated RN #107 worked in the capacity of a registered staff member for two full shifts prior to being investigated regarding the incident of witnessed abuse.

The home's policy titled "Section 3.2 Abuse and Neglect Prevention Program" last revised June 2015, indicated that the procedure for investigating a resident abuse by formal caregiver, volunteer or visitor included that the investigation would have been immediately initiated and the suspected or accused staff member would be relieved from their duties with pay while the investigation was being conducted.

Inspector #638 interviewed the Administrator who stated that they were leaving for the day when they witnessed the incident between resident #002 and RN #107. They indicated that the RN had just initiated their medication pass and did not want to interrupt the pass. Therefore, the Administrator had planned on returning to the home at a later time to discuss the incident with the RN, which did not occur. The Administrator indicated that RN #107's next shift was seven days later and that they initiated the investigation on RN #107 at that the end of their next shift. The Administrator indicated that any witnessed abuse should be investigated immediately. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee is immediately investigated, to be implemented voluntarily.

Issued on this 24th day of October, 2017

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

Original report signed by the inspector.