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

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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
Jul 18, 2014	2014_140158_0015	S-0300-14	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

KELLY-JEAN SCHIENBEIN (158)

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): July 16, 17, 2014

Log # S-3000-14 was reviewed.

During the course of the inspection, the inspector(s) spoke with the Administrator, the acting Director of Care (DOC)and Registered Nursing Staff.

During the course of the inspection, the inspector(s) reviewed health care record of a resident and reviewed various policies and procedures within the home.

The following Inspection Protocols were used during this inspection:
Pain

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. 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 did not ensure that 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.
Resident # 01 was diagnosed with a chronic degenerative disease of an organ and had sustained injury as a result of a fall, prior to their admission.
Resident # 01 health care record, including the physician's orders, progress notes and medication administration record (E-Mar) were reviewed by the Inspector on July 16, 2014.
The physician's admission orders, specifically for resident # 01's pain management, included a regularly scheduled narcotic, a narcotic to be given q3h prn (when necessary) and a regularly scheduled medication to protect the organ's absorption of the medication. The order for the regularly scheduled narcotic, which resident # 01 had taken for a month prior to the admission into the home, was discontinued one day after their admission.
Three days after the discontinuation of the narcotic, it was documented in resident # 01's progress notes by staff # 100, that the resident was having increased pain during care delivery. It was further documented by staff # 100, that they (staff # 100) contacted the ER physician and a narcotic to be given q2h prn was ordered to start. A regularly scheduled narcotic, as well as, a narcotic to be given q4h prn, was also ordered but the start date was identified the next day.
The review of resident # 01's E-Mar identified, both of the PRN medications; a narcotic to be given q3h prn and a narcotic to be given q4h prn.
It was identified on July 16, 2014 in the interview with the pharmacist, that when an order is discontinued, a "D" would auto-populate in the medication columns. There was no "D" observed in the narcotic to be given q3h prn column.
There was no documentation in the progress notes or in the physician's orders identifying whether the narcotic to be given q3h prn was discontinued.
The medication administration record (E-Mar) showed that, resident # 01 received the narcotic to be given q3h prn once on the day the order for the narcotic to be given q4h prn, was to start. Staff # 102 documented in the progress notes, that a narcotic from both PRN orders was given as well.
The (a) DOC identified that when the physician changes an order to a medication ie: the dose, it is the expectation that the Registered staff will clarify the change and receive clear direction from the physician, as outlined in the College of Nurses practice guidelines. The home does not have a policy/procedure in relation to this.
The licensee does not have a policy related to the clarification of physician orders, specifically, when the physician changes the dosage. [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 ensuring that a policy related to the clarification of physician orders, specifically, when the physician changes the dosage, is developed and implemented, to be implemented voluntarily.

WN #2: 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).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. Resident # 01 was diagnosed with a chronic degenerative disease of an organ and had sustained injury as a result of a fall, prior to their admission.
The pain assessment completed on admission, identified that resident # 01 has pain daily, which becomes severe at times. The medication administration record (E-Mar) showed that the resident received regularly scheduled narcotics on a daily basis. Resident # 01's care plan, however, did not identify, address or provide interventions to manage the resident's pain related to the resident's injury sustained from a fall. The care plan, also did not identify, address or provide interventions to manage complications associated with the resident's chronic degenerative disease of an

organ. The licensee did not ensure that the plan of care set out clear directions to manage resident # 01 pain, to staff and others who provide direct care to resident # 01. [s. 6. (1) (c)]

2. The licensee did not ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.
Resident # 01 was diagnosed with a chronic degenerative disease of an organ and had sustained injury as a result of a fall, prior to their admission. The resident was transferred to hospital when they became unresponsive. It was documented in resident # 01's progress notes, that the hospital informed the home that the resident was being treated for an adverse drug reaction.
Resident # 01 health care record, including the physician's orders, progress notes and medication administration record (E-Mar) were reviewed by the Inspector on July 16, 2014.
The physician's admission orders, specifically for resident # 01's pain management, included a regularly scheduled narcotic, a narcotic to be given q3h prn (when necessary) and a regularly scheduled medication to protect the organ's absorption of the medication. The order for the regularly scheduled narcotic, which resident # 01 had taken for a month prior to the admission into the home, was discontinued one day after their admission.
Three days after the discontinuation of the narcotic, it was documented in resident # 01's progress notes by staff # 100, that the resident was having increased pain during care delivery. It was further documented by staff # 100, that they (staff # 100) contacted the ER physician and a narcotic to be given q2h prn was ordered to start.
It is documented in a letter, written by the ER physician, who had ordered the narcotic, that when staff # 100 called to identify that resident # 01's pain was not managed, staff # 100 did not make them (Er physician) aware, that resident # 01 was previously taking a regularly scheduled narcotic. It was also documented in this letter, that the ER physician wrote that a regularly scheduled medication to protect the organ's absorption of the medication had not been ordered for resident # 01 on admission and subsequently, resident # 01 had not received it. The E-Mar showed that the resident had received a regularly scheduled medication to protect the organ's absorption of the medication since admission.
On July 15, 2014, staff # 100 stated to the Inspector that they had informed the ER physician of the resident's diagnosis and medication that was currently ordered for resident # 01. This discussion was documented in the progress notes by staff # 100.
The Inspector interviewed staff # 101 on July 16, 2014. Although, staff # 101 identified

that they spoke with the ER physician and informed the ER physician, that the order for the regularly scheduled narcotic, which resident # 01 had taken for a month prior to the admission into the home, was discontinued one day after their admission, there was no documentation found in resident # 01 progress notes to support the discussion with the ER physician by staff # 101.
The review of resident # 01's E-Mar identified, both of the PRN medications; a narcotic to be given q3h prn and a narcotic to be given q4h prn. The medication administration record (E-Mar) showed that, resident # 01 received the narcotic to be given q3h prn, once on the day, the order for the narcotic to be given q4h prn, was to start.
In the July 16, 2016 interview, Staff # 101 also identified, that clarification of the two PRN narcotic orders or the regularly scheduled narcotic, was not done.
The licensee failed to ensure that the Registered staff and the physician collaborated in the assessment of resident # 01. [s. 6. (4) (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 82. Attending physician or RN (EC)

Specifically failed to comply with the following:

s. 82. (4) The licensee shall enter into the appropriate written agreement under section 83 or 84 with every physician or registered nurse in the extended class retained or appointed under subsection (2) or (3). O. Reg. 79/10, s. 82 (4).

Findings/Faits saillants :

1. The Administrator provided the Inspector, a copy of the written agreement between them (licensee) and the Physician' Group Services, which provide medical services to the residents of the home. The agreement was dated May 2001 and it was identified in Appendix A, under item 6.0, that the agreement remains in effect for 2 years, from the date first written.
The licensee is not currently entered into a written agreement between them (licensee) and the physicians, they retain for the provision of medical services. [s. 82. (4)]

WN #4: 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):
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 did not ensure that the Director was informed of a medication incident or adverse drug reaction, in respect of which, a resident was taken to hospital, no later than one business day after the incident.
Resident # 01 had pain related to an injury. The resident also had a diagnosis of a chronic degenerative disease of an organ.
The physician's admission orders, specifically for resident # 01's pain management, included a regularly scheduled narcotic and a narcotic to be given q3h prn (when necessary). The order for the regularly scheduled narcotic, which resident # 01 had taken for a month prior to the admission into the home, was discontinued one day after their admission. The resident continued to receive a narcotic to be given q3h prn (when necessary) on as needed basis.
Three days after the discontinuation of the regularly scheduled narcotic, a narcotic to be given q2h prn (when necessary) was ordered to start. A regularly scheduled narcotic, as well as, a narcotic to be given q4h prn, was also ordered but the start date was the next day.
It was identified in the resident's progress notes that one day after the regularly scheduled narcotic was started, resident # 01 was not voiding and needed intervention. The resident became non responsive and was transferred to hospital. It was documented in resident # 01's progress notes, that the hospital informed the home that the resident was being treated for an adverse drug reaction. The licensee did not report this incident to the Director. [s. 107. (3) 5.]

Issued on this 18th day of July, 2014

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