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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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
Feb 2, 2017	2016_342611_0023	030891-16	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD THOROLD ON L2V 4T7

Long-Term Care Home/Foyer de soins de longue durée

UPPER CANADA LODGE
272 WELLINGTON STREET P. O. BOX 1390 NIAGARA-ON-THE-LAKE ON L0S 1J0

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

KELLY CHUCKRY (611), CATHY FEDIASH (214), GILLIAN TRACEY (130), IRENE SCHMIDT (510a)

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): October 25, 26, 27, 31, 2016 and November 1, 2, 3, 4, 8, 9, 2016.

During the course of this inspection inspector(s) conducted a tour of the home, observed the provision of resident care, reviewed applicable clinical health records, policies, procedures, practices, and investigation notes. Three Critical Incident inspections, and four complaint inspections were conducted concurrently with this Resident Quality Inspection.

The four complaint inspections included Log #033798-15 related to personal care, and dining and snack service, Log # 008186-16 related to personal care, skin and wound and the prevention of abuse and neglect, Log # 025746-16 related to personal care and infection prevention and control, and Log # 031317-16 related to responsive behaviours. The three Critical Incident inspections included Log # 019666-15 related to falls prevention, Log # 008468-16 related to the prevention of abuse and neglect, and Log # 027826-16 related to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with residents, family members, the Administrator, Director of Resident Care (DRC), Manager of Dietary, Housekeeping and Laundry, Registered Dietitian (RD), Food Service Supervisor (FSS), Manager of Resident and Community Programs (MRCP), Clinical Documentation and Infomatics (CDI) Coordinator, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), dietary aids, and housekeeping aides.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **7 WN(s)**
- **3 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. (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).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A review of resident #022's clinical record indicated that they sustained a fall on an identified date, when they slid to the floor. Progress notes indicated that all four extremities were assessed for full range of movement.

A post fall assessment completed on an identified date, indicated that a specified intervention was not in place as a result of a malfunction and a replacement could not be found.

A progress note dated the day before, indicated that registered staff had assessed the resident's care needs and determined that the resident no longer required the specified intervention and this was discontinued from their plan of care.

An interview with the DRC confirmed that staff had not collaborated with each other in the assessments of the resident so that their assessments were integrated, consistent and complemented each other.

This non-compliance was issued as a result of the following CIS inspection #019666-15. (Inspector #214) [s. 6. (4) (a)]

2. The licensee 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.

i) A Critical Incident System (CIS) that was submitted by the home on a identified date, indicated that resident #022 had sustained a fall, which resulted in an injury to this resident which required assessment and intervention from an outside care facility.

A review of the resident's clinical record indicated that the resident returned to the home on an identified date, following the assessment and intervention.

A review of the resident's written plan of care indicated that resident's plan had not been reviewed and revised to include the noted assessments and interventions until four (4) days following their return to the home.

An interview with the DRC confirmed that the resident's plan of care had not been reviewed and revised when their care needs changed.

This non-compliance was issued as a result of the following CIS inspection #019666-15. (Inspector #214)

ii) A review of resident #022's clinical record indicated that they sustained a fall on an identified date. Progress notes indicated that all four extremities were assessed for full range of movement.

A review of the resident's progress notes indicated that on an identified date, the Physiotherapist (PT) reported to the Registered Nurse and team at the rounds meeting that the resident demonstrated pain during treatment. A progress note on an identified date, indicated that the PT reported at the rounds meeting that the resident had complained of pain. A diagnostic test was ordered by the physician. A progress note

after the diagnostic test was completed indicated that the resident sustained an injury.

A review of the resident's progress notes from a specified period of time had not identified any documentation of an incident or occurrence since the resident sustained a fall.

A review of the post fall assessment that was completed on an identified date, indicated the resident was to be assessed to determine the need for a specified intervention. A review of the resident's written plan of care for falls indicated that this intervention was was implemented, 35 days following the completion of the post fall assessment.

An interview with the DRC confirmed that the plan of care was not reviewed and revised when the resident's care needs changed.

This non-compliance was issued as a result of the following CIS inspection #019666-15. (Inspector #214) [s. 6. (10) (b)]

3. A review of resident #001's clinical record indicated that they were at risk for falls and that on an identified date in October 2016, had sustained a fall with no injuries.

A review of the post fall assessment from a specified date, indicated under "Interventions/Action Plan", that hourly checks were required. The assessment also indicated that the care plan was reviewed and revised as necessary.

A review of the resident's current written care plan indicated that on the intervention to check the resident every one hour to ensure their safety was implemented, nine (9) days following this assessed need.

An interview with the DRC confirmed that the resident's plan of care had not been reviewed and revised when their care needs changed. [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 the staff and others involved in different aspects of care of the resident collaborate with each other, and to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with applicable requirements under the Act.

Resident #018 had a medical diagnosis that required the use of a regularly scheduled dose of a medication once daily. In addition, this resident had a physician order for the same medication to be administered up to four (4) times a day as required.

Resident #018 left the home daily on a Leave of Absence (LOA) with their family member. Prior to the LOA that took place on an identified date, the family member was handed the above noted medication during a medication pass.

The home had a policy in place entitled Ordering Medications for Leave of Absence (4-6). Item number four (4) for the procedure in this policy indicated that an Acceptance of LOA Medications form was to be completed prior to releasing medication to the resident's responsible party.

An interview conducted with staff #101 confirmed that this form was not completed. Further discussions with staff #104 and #105 confirmed that the above noted form should have been completed and this policy was not complied with. Every licensee is required to ensure that all staff comply with an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. O. Reg. 79/10 s. 114 (1).

The DRC confirmed the home's policy had not been complied with. [s. 8. (1) (b)]

2. The home's policy PCS06-005, entitled referral to Registered Dietitian, revised December 14, 2015, indicated the RD would be notified, in a timely and effective manner, when a resident's condition changed in a way that impacted his/her nutritional health and well being. The interdisciplinary team members would refer residents using the Electronic Nutritional Referral Form, when there were nutritional concerns related to a new diagnosis or when any of the following changes occurred in a resident's medical health profile. This included, but was not limited to the following:

- Significant weight change, confirmed by documented re-weigh (unintended weight loss/gain of 5% or more) in the past 30 days,
-refusal to eat for more than 3 consecutive days.

A) According to the Nutrition Report for resident #027, from a specified date, indicated that the resident refused lunch and dinner. The record showed the resident refused breakfast and lunch as well, which indicated the resident had refused four consecutive meals.
On an identified date, the resident refused, lunch and dinner and on the following day, the resident refused breakfast, lunch and dinner, which indicated a refusal of five consecutive meals. On an identified date, the resident refused dinner and on the following day, the resident refused breakfast and lunch, which indicated a refusal of three consecutive meals.

There were no electronic referrals found to indicate nursing had notified the dietary

department of the meal refusals.

In accordance with s. 11. (1), every licensee is required to ensure that there was an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents.

The Nutrition Manager confirmed there were no referrals completed as per the policy, when the resident had refused at least three consecutive meals. (Inspector #130).

This non compliance was identified as a result of complaint inspection #033798-15, which was conducted concurrently with the RQI. [s. 8. (1) (b)]

3. The home's policy PCS06-005, entitled referral to Registered Dietitian policy, revised December 14, 2015, indicated the RD would be notified, in a timely and effective manner, when a resident's condition changed in a way that impacted his/her nutritional health and well being. The interdisciplinary team members would refer residents using the Electronic Nutritional Referral Form, when there were nutritional concerns related to a new diagnosis or when any of the following changes occurred in a resident's medical health profile. This included, but was not limited to the following:

- Significant weight change, confirmed by documented re-weigh (unintended weight loss/gain of 5% or more) in the past 30 days,
- Laboratory values with nutritional implications outside of normal range (e.g.Hemoglobin and electolytes).

A) The Weight Summary Report for resident #026, identified a 5% weight loss, a 16.4 % weight gain, and a 10.7% weight loss on three separate identified dates. There were no recorded Electronic Nutritional Referral Forms completed for these weight variances.

B) On an identified date, progress notes confirmed the physician was notified regarding abnormal test results. There was no Electronic Nutritional Referral Form completed for the RD.

In accordance with s. 11. (1), every licensee is required to ensure that there was an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents.

The DRC confirmed on November 9, 2016, that policy PCS06-005 was not complied

with. (Inspector #130).

This non compliance was identified as a result of complaint inspection 025746-16, which was conducted concurrently with the RQI. [s. 8. (1) (b)]

4. The home's policy RS00-015, entitled Weight Monitoring, revised on April 1, 2016, indicated all residents would have their weight measured and recorded on admission and monthly and more often as required in order to achieve early recognition of a concern and to respond to the resident's unplanned weight change. The definition of significant weight change included, but was not limited to the following:

Significant weight change meant: a change of 5 per cent (%) of body weight, or more over one month.
For residents where a weight change was significant as indicated in the definition, "choose Progress note under action and document resident requires reweigh and sign note".

A) The Weight Summary Report for resident #026, identified significant weight changes on three separate identified dates.

There were no recorded referral progress notes requesting reweighs for the identified variances nor was there any record of the reweighs being completed.

In accordance with s. 11. (1), every licensee is required to ensure that there was an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents.

The DRC confirmed on November 9, 2016, that policy PCS06-005 was not complied with. (Inspector #130).

This non compliance was identified as a result of complaint inspection 025746-16, which was conducted concurrently with the RQI. [s. 8. (1) (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 any plan, policy, protocol, procedure, strategy, or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated. 1. A change of 5 per cent of body weight, or more, over one month. 2. A change of 7.5 per cent of body weight, or more, over three months. 3. A change of 10 per cent of body weight, or more, over 6 months. 4. Any other weight change that compromises the resident's health status.

Resident #010's documented weights were reviewed in Point Click Care (PCC) over a four (4) month period of time. The resident's documented weight over a one month period of time indicated a weight loss greater than 5 per cent. The resident's documented weight over a three month period of time indicated a weight loss greater than 7.5 per cent.

A nutritional progress note on an identified date, written by the RD indicated that resident #010 was refusing a documented intervention and the plan was to discontinue this intervention. No further action was taken to address the continued weight loss for this resident.

A subsequent progress note was completed for resident #010 and indicated a weight warning in excess of a 7.5 per cent weight loss. No further action was taken to address the continued weight loss for this resident.

An interview with the Dietary, Housekeeping, Laundry Manager confirmed that no actions were taken to address the continued weight loss for resident #010. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes evaluated when 1. there is a change of 5 percent of body weight, or more, over one month, 2. A change of 7.5 percent of body weight, or more, over three months, 3. A change of 10 percent of body weight, or more, over 6 months, 4. Any other weight changes that compromises the resident's health status, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A review of resident #022's clinical record indicated that they sustained a fall on an identified date. Progress notes indicated that all four extremities were assessed for full range of movement.

A review of the resident's progress notes indicated that on an identified date, the Physiotherapist (PT) reported to the registered nurse and team at the rounds meeting that the resident demonstrated pain during treatment. A progress note from an identified date, indicated that the PT reported at the rounds meeting that the resident had complained of pain. A diagnostic test was ordered by the physician. A progress note

from an identified date, indicated that the resident had sustained an injury as a result of the fall.

A review of the resident's progress notes from a specified period of time, had not identified any documentation of an incident or occurrence since the resident sustained a fall.

A review of the resident's written plan of care in place at the time of this fall, stated under the fall focus, "check q1h (check every one hour) to ensure safety". A review of the Point of Care (POC) documentation system identified that no documentation had been completed for the resident's hourly checks.

An interview with the DRC on November 4, 2016, confirmed that staff did check the resident hourly; however, they did not document these actions as there was no place to document them and no task had been set up in POC for the documentation of this resident's hourly safety checks.

This non-compliance was issued as a result of the following CIS inspection #019666-15. (Inspector #214) [s. 30. (2)]

2. A review of resident #001's clinical record indicated that they were at risk for falls and on an identified date in October 2016, had sustained a fall with no injuries.

A review of the post fall assessment on an identified date, indicated under "Interventions/Action Plan", that hourly checks were required. The assessment also indicated that the care plan was reviewed and revised as necessary. A review of the current written care plan indicated that the resident was to be checked every one hour to ensure safety.

A review of the Point of Care (POC) documentation system identified that no documentation had been completed for the resident's hourly checks.

An interview with the DRC on November 4, 2016, confirmed that staff did check the resident hourly; however, they did not document these actions as there was no place to document them and no task had been set up in POC for the documentation of this resident's hourly safety checks. [s. 30. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

A Critical Incident System (CIS) that was submitted by the home on an identified date, indicated that resident #022 had sustained a fall, which resulted in an injury. The resident was transferred and admitted to the hospital.

A review of the resident's clinical record indicated that the resident returned from the hospital on an identified date. A progress note indicated that the resident had altered skin integrity to a specified area on their body. Further documentation on the same day, indicated that the skin was compromised for this resident. A progress note on the same date indicated that another compromised area was noted on the resident.

An assessment titled, "Re-admission Assessment, Full (Hosp, ER, LOA with issues- May 2013)", from an identified date, indicated under the "Skin Assessment" section that the resident had an intervention in place on an area of their body, however, had not contained any assessed information of the resident's area.

A review of the resident's clinical record and confirmation during an interview with the DRC identified that a skin assessment had not been completed for resident #022 upon their return from hospital.

This non-compliance was issued as a result of the following CIS inspection #019666-15. (Inspector #214) [s. 50. (2) (a) (ii)]

2. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A Critical Incident System (CIS) that was submitted by the home on an identified date that indicated that resident #022 had sustained a fall on an identified date, which resulted in an injury. The resident was transferred and admitted to the hospital.

A review of the resident's clinical record indicated that the resident returned from the hospital on an identified date, following assessment and treatment.

A review of the resident's progress notes and assessment's in Point Click Care (PCC) were reviewed from the date the resident returned from hospital for a period of seven (7) days. A clinically appropriate assessment instrument that was specifically designed for

skin and wound assessment had not been completed for the resident's wound. An interview with the DRC confirmed that the resident had not received a skin assessment for their altered skin integrity.

This non-compliance was issued as a result of the following CIS inspection #019666-15. (Inspector #214) [s. 50. (2) (b) (i)]

3. The licensee failed to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

On an identified date, resident #025 had an initial skin and wound assessment completed. This assessment indicated that this resident had altered skin integrity to an area on their body. During a four (4) week period of time, this resident had one assessment that was completed during this time by a member of the registered nursing staff, and were not completed weekly.

An interview with staff #111 confirmed that resident #025 exhibited altered skin integrity and was not reassessed weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

4. The licensee failed to ensure that the equipment, supplies, devices and positioning aids referred to in subsection (1) were readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

A Critical Incident System (CIS) that was submitted by the home on an identified date, indicating that resident #022 had sustained a fall, which resulted in an injury. The resident required assessment and treatment at an outside care facility.

A review of the resident's clinical record indicated that the resident returned from the hospital on an identified date, following assessment and treatment for their injury.

A review of the Electronic Medication Record (EMAR) indicated that on an identified date, an order was created in the EMAR for a specified treatment. A review of the Treatment Administration Record (TAR) indicated that on an identified date indicated that the treatment was not completed, and a subsequent progress note entry indicated the treatment was not completed as there were no supplies available.

During an interview with registered staff #113 it was confirmed that the staff member could not recall the resident's injury, however, confirmed that their documentation was accurate, indicating no supplies were available.

This non-compliance was issued as a result of the following CIS inspection #019666-15. (Inspector #214) [s. 50. (2) (c)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that (a) each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence

Resident #007, was admitted to the home on an identified date, at which time the resident was reported to be fully continent for bowels and bladder.

Review of the resident's minimum data set (MDS), section H1, continence, revealed a significant change on an identified date, when the resident went from continent of bowel to occassionally incontinent and from bladder incontinence once a week or less, to incontinence twice a week or more, but not daily. Review of the assessment tab in point click care (PCC) revealed the absence of a clinically appropriate continence assessment being completed when these changes in continence were identified. This was confirmed by the resident assessment inventory (RAI) coordinator.

The DRC confirmed it was the home's expectation that an assessment, using a clinically appropriate assessment instrument, be completed when changes in continence were reported. The resident did not receive an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. [s. 51. (2) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart,
ii. that was secure and locked.

The home has a process in place for the destruction of medications, specifically the destruction of controlled substances. These controlled substances that are to be destroyed and disposed of are to be stored in a double locked storage area within the home, separate from any controlled substances that are available for administration to residents. This double locked storage area is located in the locked medication room, in a locked wooden cabinet.

During observation of this double locked storage area, staff #101 was able to pull a patch disposal record sheet out of this cabinet. This disposal sheet contained three fentanyl patches that were meant for disposal. Staff #101 confirmed that these patches were not secured in the double locked storage area.

An interview with the DRC confirmed that the Patch Disposal Record Sheet was not secured in the double locked storage area. [s. 129. (1) (a)]

Issued on this 21st day of February, 2017

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

Original report signed by the inspector.