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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 10, 2015	2015_340566_0003	T-1752-15	Resident Quality Inspection

Licensee/Titulaire de permis

REGENCY LTC OPERATING LP ON BEHALF OF REGENCY
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

THE WOODHAVEN
380 Church Street MARKHAM ON L6B 1E1

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

ARIEL JONES (566), JANET GROUX (606), NATASHA JONES (591), TILDA HUI (512)

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): February 18, 19, 20, 23, 24, 26, 27, March 2, 3, and 4, 2015.

The following critical incident intakes were also inspected: T-284-14, T-1180-14, T-1272-14, T-1900-15, T-2018-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, the acting Director of Care (DOC), the assistant director of care (ADOC), resident support services manager, director of social services, environmental services manager (ESM), nursing unit clerk, registered staff members, personal support workers (PSW), housekeeping staff, dietary aide, residents and family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
13 WN(s)
7 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. (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. (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 has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

An interview with resident #009 indicated that the resident receives oral care only once a day in the morning, and does not receive oral care in the evening before bed time.

Interviews with identified nursing staff noted that oral care was provided twice a day to resident #009, once in the morning before breakfast and once in the evening before bed time.

A record review noted that the resident requires total assistance from one staff with personal hygiene including oral care, the resident has his/her own teeth, and he/she prefers his/her teeth to be brushed by staff daily. The plan of care did not set out clear directions to staff and others who provide direct care to the resident related to the frequency of the oral care provided to the resident. [s. 6. (1) (c)]

2. A review of resident #013's written current care plan indicated that the resident is at

high risk for falls and requires extensive assistance of two staff for transfers.

On February 24, 2015, the resident was observed to be transferred from his/her wheelchair to bed by one staff. The identified PSW indicated that the resident is a one person transfer with extensive assistance, as per the transfer logo posted in the resident's room and the printed care plan/kardex at the nursing station (with an identified print date from November 2014). An interview with a second identified PSW revealed that his/her understanding was also that the resident required assistance of one person for transfers, as per the posted transfer logo.

An interview with a member of the registered staff confirmed that the resident requires assistance of two people for transfers, and that the conflicting information provides unclear directions for direct care staff. The acting DOC confirmed that it is the home's expectation that when changes are made to the electronic care plan, both the transfer logo and printed care plan/kardex binders are updated immediately. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A review of resident #026's written care plan revealed that the resident is at high risk for falls and requires identified interventions, including bed in the lowest position with a floor mat on the left side; and talking to the resident about a plan for his/her safety and minimization for risk of falls using a Posey alarm, floor mat, and other identified interventions.

Observations made at specified times on February 24 and 26, 2015, revealed that there was no floor mat in the resident's bed room. On February 27, 2015, at an identified time, there was no floor mat on the left side of the bed while the resident was lying in bed. Observations made at specified times on February 26, 2015, revealed that the resident was seated in his/her geri-chair without the chair alarm attached. The Posey alarm was observed to be sitting out on the resident's bedside table.

An interview with the identified PSW assigned to the resident confirmed that the resident requires use of a Posey alarm at all times in both his/her bed and wheelchair, and that the PSW forgot to attach the Posey alarm to the resident while he/she was up in his/her geri-chair on the day shift on the identified date.

An interview with a member of the registered staff confirmed that the resident requires

both the floor mat and Posey alarm in both the bed and geri-chair for falls prevention. The acting DOC confirmed that if the falls prevention interventions outlined in the resident's care plan are not in place, then care is not being performed as per the plan of care. [s. 6. (7)]

4. The licensee has failed to 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 the resident's care needs change.

A record review revealed that resident #010 was described as frequently incontinent during a minimum data set (MDS) assessment conducted on an identified date in November 2014. The resident was assessed to be totally incontinent in the MDS assessment conducted on an identified date in January 2015. There was no evidence of a bladder continence assessment being conducted for the resident on or after the January 2015 MDS assessment, once a status change of the resident's bladder continence level was identified.

Interviews with an identified RPN and the ADOC confirmed that a bladder continence assessment should have been conducted for the resident after a deterioration of the resident's bladder continence level was identified. [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 plan of care sets out clear directions to staff and others who provide direct care to the resident, to ensure the care set out in the plan of care is provided to a resident as specified in the plan, and to ensure that a resident is reassessed and the plan of care reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Record review revealed that resident #042 was slapped on an identified area of the body by an identified PSW in the shower room of an identified unit. The physical abuse was witnessed on an identified date and time in January 2015, by an identified PSW who reported the incident to an identified RPN on the unit approximately three hours later. The RN on duty initiated investigation per home protocol, conducted assessment on the resident, and contacted management and the police. A critical incident (CI) report was filed to the Director on an identified date and time, the next day. The alleged abuser was suspended immediately and later charged for abuse.

Interviews with the identified RPN on duty, the ADOC, and the Administrator confirmed that the resident was not protected from physical abuse by staff in the home. [s. 19. (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 residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident’s money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect by the licensee or staff that resulted in harm or risk of harm, has occurred or may occur, immediately reports the suspicion and the information upon which it was based to the Director.

Record review revealed that resident #009 alleged that a caregiver slapped him/her on an identified area of the body on an identified date in September 2014. The resident reported the allegation the following day to one of the nursing staff. The resident was assessed and no injuries were noted. Staff working on the date of the alleged incident were interviewed and camera footage with a view of the hallways was reviewed with no findings. The CI report was submitted to the Director on an identified date in September 2014, two days after the incident was alleged to have occurred. The CI report indicated that the police were not notified.

An interview with the ADOC confirmed that the Ministry of Health (MOH) was not notified immediately upon receiving the allegation from the resident of suspected abuse. [s. 24. (1)]

2. A record review revealed that resident #042 was slapped on an identified area of the body by an identified PSW in the shower room of an identified unit. The physical abuse was witnessed on an identified date and time in January 2015, by an identified PSW who reported the incident to an identified RPN on the unit approximately three hours later. The RN on duty initiated investigation per home protocol, conducted assessment on the resident, and contacted management and the police. A CI report was filed to the Director on an identified date and time, the next day. There was no evidence of a notification to the Director immediately upon receipt of the abuse allegation. The alleged abuser was suspended immediately and later charged for abuse.

Interviews with the ADOC and the Administrator confirmed that the Director was not contacted immediately upon receiving the report of suspected abuse, and that staff should have used the MOH after hours pager number to report the abuse immediately. [s. 24. (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 a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect by the licensee or staff that resulted in harm or risk of harm, has occurred or may occur, immediately reports the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident has been assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The written plan of care for resident #013 indicates that he/she is at high risk for falls. A record review revealed that resident #013 experienced an identified number of falls over the period of September 2014 to February 2015. Record review and staff interviews confirmed that neither a post fall analysis assessment or risk management assessment were completed after the resident's fall on an identified date in February 2015.

An interview with the acting DOC confirmed that, as per the home's policy, the post-fall analysis tool is to be completed after a resident's first fall in the quarter and a risk management assessment should be completed after every fall incident, whether or not an injury has been sustained. [s. 49. (2)]

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 when a resident has fallen, the resident has been assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #5: 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 has failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

An observation made at a specified time on February 24, 2015, of the medication cart on an identified unit, noted a plastic tray with two nail clippers kept in one of the drawers of the cart. A wallet with an identified amount of money was also observed inside the narcotic cupboard.

Interviews with an identified RPN and the ADOC confirmed that non drug-related items should not be kept in the medication cart or narcotic cupboard. [s. 129. (1) (a)]

2. The licensee has failed to ensure that 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.

An observation made at a specified time on February 24, 2015, noted three unlabeled paper cups with pills inside each cup stored in the top drawer of the medication cart on an identified unit. The identified RPN on duty stated that the pills were narcotic medications taken out of their original labeled package in the locked narcotic cupboard to be prepared to administer to residents at a later time.

Interviews with the identified RPN and the ADOC confirmed that the narcotics should be stored in the separate, double-locked compartment within the locked medication cart until administered to a resident. [s. 129. (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 drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies, and to ensure that 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including all areas where drugs are stored shall be kept locked at all times, when not in use.

An observation made at a specified time on February 27, 2015, noted that on an identified unit, the medication cart parked outside the dining room across from the nursing station was unlocked and unattended.

An interview with an identified registered staff confirmed that the practice of the home is to always have the medication cart locked when it is not being attended. [s. 130. 1.]

2. The licensee has failed to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

Interview with the ADOC revealed that government stock medications are kept in a storage room on the ground floor. In addition to the registered nursing staff, the environmental services manager also has access to the room.

Interviews with the acting DOC and the Administrator confirmed that the storage room where government stock medications are kept should be restricted to registered staff. [s. 130. 2.]

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 the security of the drug supply, including all medication carts where drugs are stored shall be kept locked at all times when not in use, and to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator, to be implemented voluntarily.

WN #7: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the infection prevention and control program.

Observations conducted by inspector #606 during the initial home tour on February 18, 2015, revealed the presence of a used, unlabeled black and silver hair brush, a used, unlabeled jar of petroleum jelly, and an unlabeled white bar of soap in an identified second floor spa room, and a used, unlabeled silver coloured hair brush in an identified third floor spa room.

Observations conducted by inspector #566 on February 19 and 24, 2015, revealed an unlabeled pink plastic basin sitting out on the counter top of the shared bathroom in room #406. On February 26, 2015, a label was observed to have been applied to the bottom of the basin.

An interview with the infection control lead confirmed that as per the home's infection prevention and control (IPAC) practices, all personal care items in shared bathrooms should be labeled to minimize the risk of cross-contamination, and all staff are expected to participate in the home's IPAC program. [s. 229. (4)]

2. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program by practicing hand hygiene between medication administrations.

On February 23, 2015, at a specified time, on an identified unit, an identified RPN was observed administering oral medication to an identified resident in the hallway outside the dining room. Upon completion of the administration, the RPN was observed proceeding to prepare medication for the next administration without performing hand hygiene. A bottle of hand sanitizer was noted on the medication cart.

An interview with the ADOC confirmed that the RPN should have performed hand hygiene in between medication administrations. [s. 229. (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 all staff participate in the infection prevention and control program, and to ensure that staff perform hand hygiene between medication administration to residents, to be implemented voluntarily.

WN #8: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

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).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to be treated with courtesy and respect and in a way that respects the resident's dignity by the licensee or staff.

A review of CI report #2888-000017-14 submitted by the home on an identified date in September 2014, revealed that resident #027 reported to the home that during the

previous night shift, at an identified time, the resident requested that his/her leg be repositioned by the assigned PSW as it had fallen over the edge of the bed. The resident reported that the identified PSW threw his/her leg back onto the bed, left his/her call bell out of reach and ignored him/her when he/she tried to explain to the PSW that the PSW's actions hurt his/her leg.

An interview with resident #027 on an identified date during the course of the inspection, revealed that the resident still recalled the incident. He/She stated that he/she was upset and made to feel very uncomfortable by the treatment from the identified PSW during repositioning of his/her leg. The resident stated further that he/she had requested that the PSW not be assigned to his/her care again, and the home had followed up and reassigned the PSW. The resident was satisfied with the action taken by the home.

During an interview with the identified PSW on an identified date during the course of the inspection, the PSW denied the allegations and stated that he/she did not reposition resident #027's leg that night. He/She also stated that the resident used his/her call bell several times that night so it was not out of the resident's reach.

A review of the home's investigation notes revealed that the resident's call bell was activated multiple times during the identified night shift. The accused staff member was reassigned to a different home area following the incident and disciplined by suspension and re-education on the following home policies: resident's Bill of Rights, employee standards of conduct, and resident abuse.

An interview with the acting DOC revealed that following the home's investigation, the resident's allegations could not be entirely confirmed. He/She stated that the resident has some level of lucidity, and although it may not have been rough treatment by the accused PSW staff, it was believed that their interaction upset the resident. The acting DOC reported that the identified PSW had been counseled in the past and was therefore disciplined, re-educated and moved to a different home area. The acting DOC confirmed that it was the home's belief that the resident's right to be treated with courtesy and respect was not upheld. [s. 3. (1) 1.]

2. The licensee has failed to ensure that the resident's right to be afforded privacy in treatment and in caring for his or her personal needs is fully respected and promoted.

An observation was made on February 23, 2015, at an identified time, of an injection administered to resident #038 on an identified area of the body by an identified RPN. At

the time of the injection, the resident was sitting in his/her room shared with a co-resident. The co-resident had three visitors sitting around his/her bed at the time. The RPN administered the injection without drawing the curtain around resident #038 to provide privacy.

An interview with the ADOC confirmed that the privacy curtain should be drawn at the time of injection to protect the resident's privacy during treatment. [s. 3. (1) 8.]

3. The licensee has failed to ensure the resident's right to have his/her personal health information, within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with that Act.

An observation made on February 27, 2015, at an identified time, noted the Point Click Care electronic medication administration record (e-mar) screen located on the medication cart was left open and unattended in the hallway of an identified unit, leaving an identified resident's confidential medical and health information accessible for anyone to view.

An interview with an identified member of the registered staff confirmed that the practice of the home is to always have the e-mar screen closed and locked when not attended, in order to keep resident's medical and health information confidential. [s. 3. (1) 11. iv.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system be easily seen, accessed and used by residents, staff and visitors at all times.

On February 20, 2015, at an identified time, an observation in resident room #104 revealed that the call bell for an identified bed could not be activated.

The call bell was tested and confirmed to be non-functional by an identified PSW and an identified member of the maintenance staff. The maintenance staff member followed up immediately.
The inspector tested the call bell within the next hour and confirmed that it was now functional. [s. 17. (1) (a)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's physical functioning and the type and level of assistance required for activities of daily living, including oral care.

A record review revealed that resident #001 has an identified condition and requires extensive assistance of one staff with all daily activities, including oral care. Interventions described in the resident's care plan for oral care were as follows: the resident has own natural teeth, staff are to provide mouth care daily.

Interviews with identified nursing staff indicated that during morning care and at bed time, the resident is brought to the washroom or a bowl is brought to him/her when he/she is in bed. The resident is assisted to sit up in bed, supplies are set up, then the resident can brush his/her teeth and rinse his/her mouth in an identified manner. The interventions set out in the plan of care were not based on an interdisciplinary assessment of the resident's physical functioning and the type and level of assistance required for oral care. [s. 26. (3) 7.]

2. A review of resident #010's current care plan revealed that the resident was occasionally incontinent for bladder, however the MDS assessment conducted on an identified date in January 2015, stated that the resident was totally incontinent.

An interview with the resident revealed that the resident has the urge to micturate and knows when he/she has to go. The resident stated that he/she was not given the option to be toileted for his/her bladder, and was asked to use incontinent briefs and urinate in the briefs.

Interviews with an identified RPN and the ADOC confirmed that the resident's plan of care was not based on an accurate interdisciplinary assessment of the resident's bladder continence level. [s. 26. (3) 8.]

WN #11: 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,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence.

A review of resident #010's current care plan revealed that the resident was occasionally incontinent for bladder, and that the resident requires assistance of two staff to toilet using the mechanical lift. A urinal was to be offered at night as the resident has urgency and cannot get to the washroom on time. Review of the resident's MDS assessment conducted on an identified date in January 2015, stated that the resident was totally incontinent and used incontinent briefs.

Resident interview revealed that he/she has the urge to micturate and knows when he/she has to go. The resident stated further that he/she was not given the option to be toileted for his/her bladder, and was asked to use incontinent briefs and urinate in the briefs.

Interviews with an identified PSW and RPN, and the ADOC confirmed that the resident who is unable to toilet independently some or all of the time did not receive assistance from staff to manage and maintain continence. [s. 51. (2) (c)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs remain in the original labeled container or package provided by the pharmacy service provider until administered to a resident.

An observation made on February 24, 2015, at an identified time, noted three unlabeled paper cups with pills inside each cup stored in the top drawer of the medication cart on an identified unit. The identified RPN on duty stated that the pills were narcotic medications taken out of their original labeled package in the locked narcotic cupboard to be prepared to administer to residents at a later time.

Interviews with the identified RPN and the ADOC confirmed that the narcotic medications should remain in the original labeled package provided by the pharmacy service provider until administered to the residents. [s. 126.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (4) Where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy must provide that the team composed of the persons referred to in clause (3) (a) shall document the following in the drug record:
1. The date of removal of the drug from the drug storage area. O. Reg. 79/10, s. 136 (4).
2. The name of the resident for whom the drug was prescribed, where applicable. O. Reg. 79/10, s. 136 (4).
3. The prescription number of the drug, where applicable. O. Reg. 79/10, s. 136 (4).
4. The drug's name, strength and quantity. O. Reg. 79/10, s. 136 (4).
5. The reason for destruction. O. Reg. 79/10, s. 136 (4).
6. The date when the drug was destroyed. O. Reg. 79/10, s. 136 (4).
7. The names of the members of the team who destroyed the drug. O. Reg. 79/10, s. 136 (4).
8. The manner of destruction of the drug. O. Reg. 79/10, s. 136 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy provides that the applicable team documents the following in the drug record: the reason for destruction, the date when the drug was destroyed, and the manner of destruction of the drug.

Record review revealed that the home's drug destruction record for narcotics titled "Log Record of Narcotics for Destruction" does not contain the following items on the record form: the reason for destruction, the date when the drug was destroyed, and the manner of destruction of the drug.

Interview with the ADOC confirmed that the above mentioned items were not included in the narcotic drug destruction record. [s. 136. (4)]

Issued on this 25th day of March, 2015

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

Original report signed by the inspector.