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 # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Feb 21, 2017 | 2017_491647_0002 | 000815-17 | Resident Quality Inspection |

## Licensee/Titulaire de permis

SPECIALTY CARE INC
400 Applewood Crescent Suite 110 VAUGHAN ON L4K 0C3

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

Cedarvale Lodge Retirement and Care Community
121 Morton Avenue Keswick ON L4P 2M5

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

JENNIFER BROWN (647), VALERIE PIMENTEL (557)

## 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): January 12, 13, 16, 19, 20, 23, 24, and 25, 2017.**

**During the course of this inspection the following critical incident report was inspected:**
**-016440-16 related to medication incident/adverse drug reaction, improper care or harm and reporting matters to the Director.**

**During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Environmental Services Manager (ESM), Physician/Medical Director, Pharmacy Manager, Physiotherapist (PT), Physiotherapist Assistant (PTA), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), President's of Residents' Council and Family Council, residents and families.**

**During the course of this inspection the inspectors: reviewed clinical records, conducted a tour of the home, completed observations of medical administration, staff and resident interactions, provisions of care, and reviewed all relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Falls Prevention**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Reporting and Complaints**
**Residents' Council**

**During the course of this inspection, Non-Compliances were issued.**
- **8 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 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 secure and locked.

In January, 2017, the inspector observed a bottle of medication sitting on top of the medication cart unsupervised. There were no registered staff in the vicinity and residents were observed to be wandering in the vicinity of the medication cart. The inspector waited at the medication cart until the registered staff member returned.

Interview with Registered staff as to why the open bottle of medication had been left sitting on the top of the medication cart, he/she replied I was only gone a minute. The Registered staff member agreed that it had not been safe practice when residents were wandering around the cart and stated that the cart should be locked up and medication should not be left sitting on top of the cart.

Interview with the DOC confirmed the Registered staff member did not ensure the medication was stored in the locked medication cart in his/her absence and it is an expectation that all medications are secured and locked in the medication cart when no registered staff are present. [s. 129. (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 drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.***

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**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. (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 care set out in the plan of care, provided to the resident as specified in the plan.

During the homes' RQI it had been observed on several occasions that an identified resident had one bedrail engaged.

A review of the resident's clinical records including progress notes and plan of care indicated that the resident had been able to move independently and required no assistance to get in and out of bed and indicated no documentation of the rationale for bedrail use.

Interviews with Registered staff and direct care nursing staff indicated that resident does not require the use of a bedrail. The direct care staff further indicated that the care

provided to the identified resident had not been care that had been specified in his/her plan.

An interview with the DOC confirmed that the plan of care for the above mentioned resident had not included the use of a bedrail and further confirmed that the care provided to resident had not followed the plan of care. [s. 6. (7)]

2. During the homes' RQI, an identified resident triggered related to a fall. Record review of the plan of care including progress notes and incident notes identified that the identified resident had 5 falls in 36 days.

Four dates in January, 2017, the inspector observed that there was no bed pad alarm on the identified resident's bed.

Record review of the written plan of care for the identified resident identified the resident was to have a bed pad alarm on his/her bed as he/she was at risk for falls. This intervention was to be initiated in October, 2016.

Interview with direct care staff confirmed there were no bed alarm pads available at the time and indicated that it had been brought to the Registered staffs' attention, the direct care staff stated the Registered staff was going to find one. When asked if the resident had an alarm, he/she indicated sometimes the resident is put to bed using a chair alarm.

Interview with a Registered staff member confirmed the resident had a bed alarm pad as far as he/she knew and he/she was not aware the staff were using the chair alarm.

On an identified date in January, 2017, direct care staff, Registered staff member and the inspector went to the resident's room to look for the bed pad alarm, no bed alarm pad was observed. The identified staff mentioned above confirmed there was no bed pad alarm on resident's bed.

Interview with the DOC confirmed residents' care was not provided as specified in his/her plan of care. [s. 6. (7)]

3. 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 or care set out in the plan is no longer necessary.

A review of an identified residents' RAI-MDS assessment records revealed that the resident had been assessed in May, 2016 as usually continent of urine, the RAI-MDS assessment dated in August, 2016, indicated that the resident had a change in urinary status and had now been assessed as being occasionally incontinent, and the RAI-MDS assessment dated November, 2016, indicated that the resident had a change in urinary status and had now been assessed as being frequently incontinent.

Record review of the identified resident indicated that the resident did not have his/her plan of care revised to reflect the change in continence status. The current written plan of care indicated that the identified resident had still been continent and required no level of assistance.

Interviews with Registered staff indicated that written plans of care are to be revised with any resident change. The Registered staff further confirmed that the written plan of care had not been reviewed or revised when the care needs had changed from continent to incontinent.

An interview with the DOC indicated that the expectation of the home is to reassess and revise the plan of care at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary. The DOC further confirmed that the written care plan for the above mentioned resident had not been reassessed or revised. [s. 6. (10) (b)]

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**WN #3: 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 homes' policy titled "Falls Prevention", Policy #: VII-G-30.00, revised January 2015, identifies the resident safety committee or falls committee is to review all fall incidents.

Resident safety meetings are held monthly to review the previous month's falls.
-minutes of the December 2016, minutes were reviewed, there was no notation of an identified resident as having two falls in November 2016.
-minutes of the January 2017, minutes were reviewed, there was no notation of an identified resident as having a fall in December 2016.
-January meeting had not occurred and the identified resident had another 3 falls as of January, 2017.

Interview with the DOC confirmed the homes fall prevention policy had not been followed as the above mentioned resident had not been reviewed during the monthly resident safety committee meetings in December 2016 and January 2017. [s. 8. (1) (b)]

2. Medical Pharmacies Manual, policy "The Medication Pass", policy "#3-6", dated January 2014, indicates the nurse will document on the electronic Medication Administration Record (eMAR) the administration of the medication.

In January, 2017, during the medication review, the inspector observed on an identified residents' Monitored Medication Record for 7-Day Card a documentation discrepancy on the medication record. Review of the eMAR's for November and December 2016, and January 2017, identified seven omissions in documenting on the eMAR and no Registered staff had documented on the eMAR on the identified days.

An interview with the DOC confirmed it is an expectation that the registered staff document on the eMAR at the time of administration of any medication.

Medical Pharmacies Manual, policy "Individual Monitored Medication Record", policy "#6-5", dated January 2014, indicates to document the total number of tablets, capsules, volume of liquid, number of patches or ampoules received in the quantity/remaining column for each order received by pharmacy. This policy further indicates the nurse is to sign the Individual Monitored Medication Record each time a dose is administered and to include date, time, amount given, amount wasted and the new quantity remaining.

In January, 2017, during the medication review, the inspector observed an identified residents' Monitored Medication Record for 7-Day Card a documentation discrepancy on the medication record. Review of the eMAR's for January 2017, identified four occasions that did not include time the medication had been administered, and one occasion did not include date, time, amount given or new quantity remaining.

An interview with the DOC confirmed it is an expectation that the registered staff document on the Individual Monitored Medication Record the date, time, amount given as directed by the policy.

Medical Pharmacies Manual, policy "Shift Change Monitored Drug Count", policy "#6-6", dated January 2014, indicated two registered staff (leaving and arriving) together count the actual amounts of medication remaining and confirm the actual quantity is the same as the amount recorded on the "Individual Monitored Medication Record", if there are discrepancies, this is to be reported to the DOC.

In January, 2017, during a medication review, the inspector observed an identified residents' Monitored Medication Record for 7-Day Card and a medication had not been signed as administering the medication on this record or on the eMAR. At an identified time the Monitored Medication Record for 7-Day Card indicated that there were 2 tablets of a specific medication remaining and on the Shift Change Monitored Drug Count record there were 2 tablets remaining. At a later time on the same day the Monitored Medication Record for 7-Day Card showed there were 2 tablets of an identified medication and the Shift Change Monitored Drug Count record identified there were 8 tablets remaining. The evening shift had received a new blister pack containing 7 tablets for the resident, therefore the 1 remaining tablet plus the new card of 7 tablets would account for the shift count then showing 8 tablets. The registered staff did not confirm the actual quantity remaining on the Individual Monitored Medication Record and the Shift Change Monitored Drug Count record on the identified date.

An interview with a Registered staff member confirmed he/she must have missed counting the Individual Monitored Medication Record at the identified time with the oncoming night nurse but the counts on the blister pack and the shift change monitored drug count were correct.

An interview with the DOC confirmed it is an expectation that the registered staff both outgoing and incoming count together to ensure the Shift Change Monitored Drug Count and the Individual Monitored Medication Record that the quantities are the same as

directed by the policy.

Medical Pharmacies Manual, policy "Shift Change Monitored Drug Count", policy #6-6, dated January 2014, indicates on the written policy the registered staff are to record the resident name, medication and strength on the "Shift Change Monitored Medication Count" form. On the form dated 2014, it indicates also to include the prescription number. This is not noted in the policy.

In January, 2017, during the medication review, the inspector observed that the record review of the home's Shift Change Monitored Drug Count records did not include the prescription numbers for the identified residents and the emergency stock supply.

An interview with the DOC confirmed it is an expectation that the registered staff are to ensure the Shift Change Monitored Drug Count record is to include the prescription number.

Medical Pharmacies Manual, policy "The Drug Record Book", policy #4-1, dated January 2014, indicates The Drug Record Book must be maintained and kept in the home for at least two years. As well as, to ensure the following information is recorded upon receiving a medication FOR paper Drug Record Book's:
-Quantity,
-Prescription number,
-Signature/initial of person receiving order,
-Date order was received, and
-Explanation of any cancelled, altered, or duplicated entries.

Review of a Critical Incident, dated May, 2016, reported that there had been a medication incident or adverse drug reaction to an identified resident when he/she had been administered a medication. The inspector requested the drug record book to review the receipt of the medication. As well, in January, 2017, during the medication review, the inspector reviewed the drug record book.

Review of the drug record book pages maintained at the nursing station, contained the following pages, 7, 8, 9, 10, 11, 55 and 56 in regards to medications the following was observed:
Page 7 – three orders for medication did not identify the prescription number, quantity, received by or date received.
Page 8 – two orders for medication did not identify the prescription number, quantity,

received by or date received.
Page 10 - two orders for medication did not identify the prescription number, quantity, received by or date received.
Page 11 - one order for medication did not identify the prescription number, quantity, received by or date received.
A total of medications were recorded in the drug record book and three were processed correctly, 28 per cent.

The home could not produce the identified residents' page from the drug record book for the identified medication. The DOC contacted the pharmacy to see if they had a copy. The pharmacy then produced a copy of the record. Upon receipt of this page, identified as page number 91, the home did not record the quantity received, prescription number, signature/initial of person receiving order and date order was received.

An interview with the DOC confirmed it is an expectation that the registered staff follow the homes policy and that the following information is recorded upon receiving any medication; quantity, prescription number, signature/initial of person receiving order and date order was received. The DOC confirmed that the home did not maintain two years of records in the home as he/she could not find the page requested for the above mentioned residents' medication. [s. 8. (1) (b)]

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints**

**Specifically failed to comply with the following:**

**s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure when they receive a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director.

Review of a Critical Incident, dated May, 2016, reported that there had been a medication incident or adverse drug reaction to an identified resident when he/she had been administered a medication. In reviewing the description of the incident, it identified that the substitute decision maker (SDM) had delivered a letter of concern dated May, 2016, to the DOC. The letter was in regards to follow-up about a serious medication error involving their loved one.

An interview with the DOC confirmed he/she did receive the letter from the SDM but it was not forwarded to the Director. [s. 22. (1)]

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement**

**Specifically failed to comply with the following:**

**s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).**

**s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:**
**1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).**
**2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).**
**3. The use of the PASD has been approved by,**
**i. a physician,**
**ii. a registered nurse,**
**iii. a registered practical nurse,**
**iv. a member of the College of Occupational Therapists of Ontario,**
**v. a member of the College of Physiotherapists of Ontario, or**
**vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).**
**4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).**
**5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the PASD that is used to assist a resident with a routine activity of living is included in the residents' plan of care.

During the homes' RQI it had been observed on several occasions that an identified resident had one bedrail engaged.

A review of the identified residents' clinical records including progress notes and plan of care indicated that the resident had been able to move independently, required no assistance to get in and out of bed and indicated no documentation of the rationale for bedrail use.

Interviews with Registered staff and direct care staff all confirmed that the identified resident has a bedrail in use while in bed however indicated that resident does not require the use of a bedrail while in bed. The above mentioned direct care staff further indicated that the use of the bedrail as a PASD is not included in the plan of care.

An interview with the Director of Care confirmed that the plan of care for resident #003 had not included the use of a bedrail and further confirmed that the use of a PASD had not been included in the plan of care. [s. 33. (3)]

2. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living included in a resident's plan of care only if the use of the PASD has been approved by
i. a physician
ii. a registered nurse
iii. a registered practical nurse
iv. a member of the College of Occupational Therapists of Ontario
v. a member of the College of Physiotherapists of Ontario, or any other person provided for in the regulations.

During the homes' RQI it had been observed on several occasions that an identified resident one bedrail engaged.

A review of resident's clinical records including progress notes and plan of care indicated that the resident had been able to move independently while in bed, required no assistance to get in and out of bed and indicated no documentation of the rationale for bedrail use.

Interviews with Registered staff and direct care staff all confirmed that the identified resident has a bedrail in use while in bed however indicated that resident does not require the use of a bedrail while in bed. Registered staff further indicated that the use of the PASD for the resident had not been approved by a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario or a member of the College of Physiotherapists of Ontario, or any other person

provided for in the regulations.

An interview with the Director of Care confirmed that the bed rail used as a PASD for the resident had not been approved by use from the above mentioned individuals. [s. 33. (4) 3.]

3. During the homes' RQI it had been observed on several occasions that an identified resident had one bedrail engaged.

A review of the resident's clinical records including progress notes and plan of care indicated that the resident had been able to use the bed rails while in bed to assist in rolling over.

Interviews with Registered staff and direct care staff all confirmed that the resident has a bedrail in use while in bed. Registered staff further indicated that the use of the PASD for the resident had not been approved by a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario or a member of the College of Physiotherapists of Ontario, or any other person provided for in the regulations.

An interview with the Director of Care confirmed that the bed rail used as a PASD for the above mentioned resident had not been approved by use from the above mentioned individuals. [s. 33. (4) 3.]

4. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living included in a resident's plan of care only if:
•The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

During the homes' RQI it had been observed on several occasions that resident an identified resident had one bedrail engaged.

A review of residents' clinical records including progress notes and plan of care indicated that the resident had been able to move independently while in bed, required no assistance to get in and out of bed and indicated no documentation of the rationale for bedrail use.

Interviews with Registered staff and direct care staff all confirmed that the resident has a bedrail in use while in bed however indicated that resident does not require the use of a bedrail while in bed. Registered staff further indicated that the use of the PASD for the resident had not been consented for from the substitute decision maker as resident is unable to consent for his/her own care.

An interview with the Director of Care confirmed that the bed rail used as a PASD for the resident had not been consented for use from the substitute decision maker. [s. 33. (4) 4.]

5. During the homes' RQI it had been observed on several occasions that an identified resident had one bedrail engaged.

A review of the resident's clinical records including progress notes and plan of care indicated that the resident had been able to use the bed rails while in bed to assist in rolling over.

Interviews with Registered staff and direct care staff all confirmed that the resident has a bedrail in use while in bed. Registered staff further indicated that the use of the PASD for the identified resident had not been consented for from the substitute decision maker as resident is unable to consent for his/her own care.

An interview with the Director of Care confirmed that the bed rail used as a PASD for the resident had not been consented for use from the substitute decision maker. [s. 33. (4) 4.]

6. During the homes' RQI, an identified resident triggered related to potential use of bed rails as a restraint. Inspector observed an identified resident to have his/her one side rail up on his/her bed on four occasions.

Record review of the written care plan identified the following under bed mobility:
-uses bed rails to move in bed revised in November, 2016, and then revised to,
-resident requires 2 half bed rails when in bed revised January, 2017.

Record review of the plan of care did not have a consent for the use of a personal assistance services device (PASD) on the identified residents' chart.

Interview with direct care staff identified the resident used the two bed rails to prevent

him/her from falling out of bed, as well as, to position him/herself while in bed.

Interview with Registered staff when asked what a PASD is responded that he/she did not know. Definition reviewed as per legislation with Registered staff member. When questioned further about the use of the two partial bed rails, he/she confirmed the home does not consider the use of two partial bed rails as a restraint but rather a PASD. He/she also confirmed there is no consent on the resident's chart approving the use of two bed rails as a PASD to assist him/her with position.

Interview with the DOC confirmed there was no written consent on the above mentioned residents' chart for the use of two side rails as a PASD by the substitute decision maker (SDM) as the resident him/herself cannot consent related to his/her cognition level. [s. 33. (4) 4.]

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**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 has failed to ensure that the resident who is incontinent received an assessment that:

-includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident change

A review of an identified residents' RAI-MDS assessment records revealed that the resident had been assessed in June, 2016 as continent of urine, the RAI-MDS assessment dated September, 2016, indicated that the resident had a change in urinary status and had now been assessed as being frequently incontinent.

Record review of the above mentioned resident indicated that the resident did not have a bladder and bowel continence assessment that includes identification of causal factors, patterns, types of incontinence, medications and potential to restore function when the continence status changed from continent to frequently incontinent.

Interviews with Registered staff indicated that residents are assessed for incontinence on admission, or with any change in health status, using the computerized bladder and bowel continence assessment located in Point Click Care. The registered staff indicated that this form is used for the identification of causal factors, patterns and types of incontinence, and medications. The above mentioned Registered staff further indicated that the resident should have been assessed using the bowel and bladder continence assessment tool when the continence status had changed.

An interview with the Director of Care indicated that the expectation of the home is to ensure the 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 is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require follow the above mentioned policy and have residents assessed using the bowel and bladder continence assessment tool for all admissions and change of status.

The Director of Resident Care further confirmed that the home did not comply and did not ensure a bowel and bladder continence assessment had been completed for the residents' change of continence status. [s. 51. (2) (a)]

2. A review of an identified residents' RAI-MDS assessment records revealed that the resident had been assessed in May, 2016 as usually continent of urine, the RAI-MDS assessment dated August, 2016, indicated that the resident had a change in urinary status and had now been assessed as being occasionally incontinent, and the RAI-MDS assessment dated November, 2016, indicated that the resident had a change in urinary status and had now been assessed as being frequently incontinent.

Record review of the identified resident indicated that the resident did not have a bladder and bowel continence assessment that includes identification of causal factors, patterns, types of incontinence, medications and potential to restore function when the continence status changed from continent to frequently incontinent.

Interviews with Registered staff indicated that residents are assessed for incontinence on admission, or with any change in health status, using the computerized bladder and bowel continence assessment located in Point Click Care. The registered staff indicated that this form is used for the identification of causal factors, patterns and types of incontinence, and medications. The Registered staff further indicated that the resident should have been assessed using the bowel and bladder continence assessment tool when the continence status had changed.

An interview with the Director of Resident Care indicated that the expectation of the home is to ensure that the resident who is incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require to follow the above mentioned policy and have residents assessed using the bowel and bladder continence assessment tool for all admissions and change of status.

The Director of Resident Care further confirmed that the home did not comply and ensure the resident has been assessed when the resident had a change of continence status. [s. 51. (2) (a)]

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**WN #7: 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 has failed to 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): A medication incident or adverse drug reaction in respect of which a resident is taken to hospital.

Review of a CI report, dated May, 2016, reported that there had been a medication incident or adverse drug reaction to an identified resident when he/she had been administered a medication in April, 2016. The CI was not submitted to the Director until May, 2016.

The DOC confirmed the report was not initiated or submitted at the time of the incident and had been later initiated in May, 2016, the day after the home received a written complaint from the SDM. The DOC confirmed the report was not submitted to the Director immediately. [s. 107. (3) 5.]

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

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

Review of the homes' annual evaluation of the medication management system was reviewed for 2016. The period of review was March 2015 to March 2016. The report identified the following members who participated in the review as: the executive director, registered nurse extended class, director of dietary services, director of resident programs, DOC and a registered practical nurse and resident assessment instrument coordinator.

An interview with the DOC confirmed that the medication management system is reviewed annually. When asked who were the members of the committee he/she indicated that it would be the members as identified above. When asked if the director of dietary services was a registered dietitian (RD) they replied no. When asked if the RD, medical director and pharmacist participated in the review they confirmed that those members of the team did not participate. The DOC confirmed all members of the interdisciplinary team did not meet annually to review the medication management system. [s. 116. (1)]

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**Issued on this 22nd day of February, 2017**

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

**Original report signed by the inspector.**