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

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 10, 2014	2014_336580_0013	S-000299-14	Resident Quality Inspection

Licensee/Titulaire de permis

The McCausland Hospital
208 Cartier Road, , TERRACE BAY, ON, P0T-2W0

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

WILKES TERRACE
208 Cartier Road, , TERRACE BAY, ON, P0T-2W0

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

VALA MONESTIMEBELTER (580), LAUREN TENHUNEN (196)

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): July 15, 16, 17, 18, 21, 22 and 23, 2014

During the course of the inspection, the inspector(s) spoke with residents and their families, the Director of Nursing (DON), the RPN Lead, who is also the Care Plan Coordinator and RAI Coordinator (RPN Lead), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the Community Program Manager (CPM), Housekeeping Aides (HAs), the Registered Dietitian (RD), the Nutrition Manager, who is also a Cook 1 (NM) and Dietary Aides (DAs).

During the course of the inspection, the inspector(s) conducted a daily walk-through of the Home, made direct observations of the delivery of care and services to the resident, observed staff to resident interactions, reviewed resident health care records and reviewed various policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. On July 22, 2014 Inspector #580 reviewed resident #2639’s Bowel and Bladder Assessment which indicated that the formerly worsening bladder problem had become stable.

On July 17, 2014 the DON told Inspector #580 that care plans are revised when there is a change in a resident’s condition. On July 17, 2014 staff #201 told Inspector #580 that the Lead RPN and multidisciplinary committee try to update the care plan quarterly. On July 22, 2014 staff #201 told Inspector #580 that resident #2639 is incontinent at night, asks to go to the bathroom during the day, wears a continence product and has had no assessment to decide whether wearing a product is needed however the PSWs decided that the resident needed a continent product. On July 22, 2014 staff #205 told Inspector #580 that resident #2639’s care plan has the following information relating to continence and toileting issues, is incontinent at night and wears a brief, soaks the bed at night, wears pull ups during the day, will ask during the

day to go to the toilet, uses a lift with a bar for transfer to the toilet, gets no tea or coffee before bedtime and is toileted after supper and before bed. On July 22, 2014 staff #206 told Inspector #580 that resident #2639 care plan has the following information relating to continence and toileting issues: a brief at night, pull ups during the day, and that can go to the bathroom on their own.

On July 22, 2014 Inspector #580 reviewed the Home's McCausland Hospital Policy/Procedure on LTC-Continence Program B3.15 dated February 2014 which indicates that the residents shall receive care and services consistent with their care plan, that continence management includes assessment for incontinence, the promotion of continence, the proper use of continence-care products, appropriate toileting routines, and the evaluation of each resident's care plan to ensure the continence program is being managed effectively, that individualized continence care programs will be based on each resident's needs and will be developed to maximize independence, comfort and dignity and reviewed quarterly or after any significant change in health status; and that individual care plans will be developed including a voiding monitoring record.

On July 22, 2014 Inspector #580 reviewed the care plan for resident #2639 which included the interventions of: change during night if possible, use incontinent products at night, disposable/reusable diapers, respond to toileting requests as soon as possible and do not toilet by self, use a mechanical lift; call bell to be within reach, and encourage client to use to call staff, client uses a pad at night, disposable/reusable diapers – small/medium/large size and needs help with clothing.

The licensee failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. On July 17, 2014 the DON told Inspector #580 that care plans are completed in MED e-Care from RAP triggers and care plans are revised when there is a change in a resident's condition. On July 16, 2014, staff #202 told Inspector #580 that printed care plans are kept in a binder behind the nursing station for all PSWs and registered staff to access. On July 22, 2014 staff #201 told Inspector #580 that resident #2643 refuses to go to the bathroom, states that it is the staff's job to change them and that the resident had an assessment done but with no follow up and no encouragement to have the resident go the washroom. On July 22, 2014 staff #205 told Inspector #580 that they are not aware of what is in resident #2643's care plan when asked about the

resident's care information relating to continence and toileting issues but stated that the resident is incontinent at night, needs excessive direction when to toilet;
-is toileted every two hours, that the resident wears a different sized brief from the pull up so that the brief does not fall down and that the resident does not have "the know" that they have to go to the bathroom or when to go when on the toilet and that the resident is incontinent when lying down. On July 22, 2014 staff #206 told Inspector #580 that resident #2643's care plan has the following information relating to continence and toileting issues: the resident is to be toileted before and after meals and in the morning and evening, the resident is ambulatory but requires reminders and that the resident wears a brief day and night.

On July 17, 2014 staff #201 told Inspector #580 that:
-the multidisciplinary committee of the physiotherapist, the dietitian, the Lead RPN and the CPM meet weekly to discuss the resident including the six week , annual and family care conferences;
-the Lead RPN completes the entire care plan, prints it, asks the Home's RPNs and PSWs for input, updates the plan in writing, and places the individual care plans into one binder in room behind the nursing station for all staff to use;
- the physiotherapist, the dietitian and the CPM do not input information electronically into the MED e-Care care plan or onto the printed copy; and
-the Lead RPN and multidisciplinary committee try to update the care plan quarterly.

On July 22, 2014 Inspector #580 reviewed the Home's McCausland Hospital Policy/Procedure on LTC-Continence Program B3.15 dated February 2014 which indicates:
-the residents shall receive care and services consistent with their care plan
-continence management includes assessment for incontinence, the promotion of continence, the proper use of continence-care products, appropriate toileting routines, and the evaluation of each resident's care plan to ensure the continence program is being managed effectively
-individualized continence care programs will be based on each resident's needs and will be developed to maximize independence, comfort and dignity and reviewed quarterly or after any significant change in health status.
-individual care plans will be developed including a voiding monitoring record.

On July 22, 2014 Inspector #580 reviewed the care plan for resident #2643 which indicates the following interventions: provide pericare after each incontinence, use disposable/reusable diapers – small/medium/large, call bell to be within reach, and

encourage client to use to call staff, disposable/reusable diapers – small/medium/large size, routine toileting by staff.

The licensee failed to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

3. The care plan for resident #2626 as found in the care plan binder was reviewed by inspector #196 for information pertaining to continence care. Under the problem of "toileting" it notes "disposable/reusable diapers - small/medium/large size" and under the problem of "bowel" it notes "toilet at the same time each day to prevent incontinence, use disposable/reusable diapers - small, medium, large, change PRN, use incontinent products at nights". The information in the written plan of care does not give clear directions as to what size products to use, what type and when to toilet each day.

The licensee failed to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

4. The current care plan for resident #2634 was obtained and reviewed by inspector #196. The care plan included the problem of "Restraints" and included the expected outcome of "client will not have an increase in use of restraints" and has the interventions of "provide client with call bell when in bed" and "ensure that one side rails is up for clients emotional comfort and security". An interview was conducted with staff #204 on July 23, 2014 and it was identified that there are no restraints used for this resident and that the care plan is not accurate. Subsequently, the problem of "restraints" that is included in the care plan does not provide clear directions to staff and others who provide care to resident #2634.

The licensee failed to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

5. On July 15, 2014, during the stage one process of the RQI, Inspector #580 observed that both quarter rails were in the "up" position on resident #2643's bed. The most recent MDS assessment identifies the use of "other types of side rails used: daily". The written care plan as found in the care plan binder, did not include

reference for the use of side rails on the resident's bed and therefore did not set out clear directions to staff and others who provide direct care to resident #2643.

The licensee failed to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

6. The care plan for resident #2643 was reviewed for information about the resident's continence requirements. Under the problem of "Bladder" the intervention of "use disposable/reusable diapers – small/medium/large" and under the problem of "Toileting" the same intervention is recorded. Staff #206 reported to Inspector #580 that this resident uses a brief day and night and staff #205 reported the resident wears a different size brief from the pull up so that the brief does not fall down. These staff members provided conflicting information regarding the size of briefs and types that are used by resident #2643 and the care plan does not specify this either.

The licensee failed to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

7. The current care plan for resident #2623 was reviewed. Under the problem listing of "toileting" it includes the intervention of use a specific piece of equipment for toileting and will try to remove it for a short time and under the problem of "sleep and rest" it includes the intervention of "toilet before bedtime and establish a toileting routine during the night". Interview was conducted with staff #204 on July 23, 2014 and it was reported that resident #2623 no longer uses a specific piece of equipment for toileting and that this was discontinued about a year ago and "when the resident is sleeping, don't wake the resident up to toilet the resident". An interview was then conducted with staff #201 and it was reported that there is no toileting routine during the night and that the care plan is not accurate. The contents of the care plan is not accurate and therefore the written plan of care does not provide clear directions to staff who provide care to the resident.

The licensee failed to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

8. On July 22, 2014 Inspector #580 reviewed the care plan for resident #2643 which

indicates the following interventions: provide pericare after each incontinence; use disposable/reusable diapers – small/medium/large; call bell to be within reach, and encourage client to use to call staff; and routine toileting by staff.

On July 22, 2014 staff #205 told Inspector #580 that they are not aware of what is in resident #2643's care plan when asked about the resident's care information relating to continence and toileting issues but stated the following: the resident is incontinent at night, needs excessive direction when to toilet, is toileted every two hours, the resident wears a different size brief than pull up so that the brief does not fall down; and the resident does not "know" that they have to go to the bathroom or when to go when on the toilet and that the resident is incontinent when lying down.

On July 22, 2014 staff #206 told Inspector #580 that they think that resident #2643's care plan has the following information relating to continence and toileting issues: the resident is to be toileted before and after meals and in the morning and evening the resident is ambulatory but requires reminders to go to the washroom and that the resident wears a brief day and night.

On July 22, 2014 Inspector #580 reviewed the Home's McCausland Hospital Policy/Procedure on LTC-Continence Program B3.15 dated February 2014 which indicates:
-the residents shall receive care and services consistent with his/her care plan;
-continence management includes assessment for incontinence, the promotion of continence, the proper use of continence-care products, appropriate toileting routines, and the evaluation of each resident's care plan to ensure the continence program is being managed effectively;
-individualized continence care programs will be based on each resident's needs and will be developed to maximize independence, comfort and dignity and reviewed quarterly or after any significant change in health status.

The licensee failed to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

9. On July 22, 2014 Inspector #580 reviewed the care plan for resident #2639 which indicates the following interventions: change during night if possible, use incontinent products at night, disposable/reusable diapers –large, respond to toileting requests as soon as possible and do not toilet by self- use a mechanical lift; call bell to be within

reach, and encourage client to use to call staff; client uses a soaker pad at night; disposable/reusable diapers – small/medium/large size; and needs help to pull down trousers and underwear.

On July 22, 2014 staff #201 Lead RPN told Inspector #580 that resident #2639 is incontinent at night, asks to go to the bathroom during the day, wears a continence product and has had no assessment to decide whether wearing a product is needed however the PSWs decided that the resident needed a continent product. On July 22, 2014 staff #205 told Inspector #580 that they believe that resident #2639's care plan has the following information relating to continence and toileting issues: incontinent at night and wears a brief, soaks the bed at night, wears pull ups during the day, will ask during the day to go to the toilet, uses a lift with a bar for transfer to the toilet, gets no tea or coffee before bedtime and is toileted after supper and before bed. On July 22, 2014 staff #206 told Inspector #580 that resident #2639's care plan has the following information relating to continence and toileting issues a brief at night, pull ups during the day, and that can go to the bathroom on their own.

On July 22, 2014 Inspector #580 reviewed the Home's McCausland Hospital Policy/Procedure on LTC-Continence Program B3.15 dated February 2014 which indicates that the residents shall receive care and services consistent with his/her care plan, that continence management includes assessment for incontinence, the promotion of continence, the proper use of continence-care products, appropriate toileting routines, and the evaluation of each resident's care plan to ensure the continence program is being managed effectively, that individualized continence care programs will be based on each resident's needs and will be developed to maximize independence, comfort and dignity and reviewed quarterly or after any significant change in health status; and that individual care plans will be developed including a voiding monitoring record.

The licensee failed to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

10. On July 22, 2014 Inspector #580 reviewed the care plan for resident #2643 related to:
a) Bladder due to absence of routine, poor hygienic techniques
-provide pericare after each incontinence
-use disposable/reusable diapers – small/medium/large

b)Toileting related to absence of routine, cognitive impairment, use of laxative/cathartic
-call bell to be within reach, and encourage client to use to call staff
-disposable/reusable diapers – small/medium/large size
-routine toileting by staff.

On July 17, 2014, staff #201 told Inspector #580 that the Lead RPN completes the entire care plan and asks the Home's RPNs and PSWs for input. On July 17, 2014 the DON told Inspector #580 that care plans are completed in MED e-Care from RAP triggers and care plans are revised when there is a change in a resident's condition. On July 22, 2014 staff #201 told Inspector #580 that resident #2643 had an assessment done but with no follow-through related to updating of the care plan.

On July 22, 2014 Inspector #580 reviewed the Home's McCausland Hospital Policy/Procedure on LTC-Continence Program B3.15 dated February 2014 which indicates:
-continence management includes assessment for incontinence, the promotion of continence, the proper use of continence-care products, appropriate toileting routines, and the evaluation of each resident's care plan to ensure the continence program is being managed effectively
-individualized continence care programs will be based on each resident's needs and will be developed to maximize independence, comfort and dignity and reviewed quarterly or after any significant change in health status.
-individual care plans will be developed including a voiding monitoring record.

The licensee failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. [s. 6. (2)]

11. On July 22, 2014 Inspector #580 reviewed the care plan for resident #2639 related to:
a) Bladder due to impaired mobility and inadequate fluid intake, change during night if possible, use incontinent products at night, disposable/reusable diapers –large, respond to toileting requests as soon as possible and do not toilet by self use a mechanical lift;
b) Toileting due to cognitive impairment, decrease strength in lower extremities, poor balance with interventions of call bell to be within reach, and encourage client to use to call staff, client uses a soaker pad at night, disposable/reusable diapers – small/medium/large size and needs help with clothing and underwear.

On July 22, 2014 Inspector #580 reviewed resident #2639's Bowel and Bladder Assessment which indicated that the formerly worsening bladder problem had become stable. On July 22, 2014 staff #201 told Inspector #580 that resident #2639 is incontinent at night, asks to go to the bathroom during the day, wears a continence product and has had no assessment to decide whether wearing a product is needed however the PSWs decided that the resident needed a continent product.

On July 22, 2014 Inspector #580 reviewed the Home's McCausland Hospital Policy/Procedure on LTC-Continence Program B3.15 dated February 2014 which indicates that the residents shall receive care and services consistent with his/her care plan, that continence management includes assessment for incontinence, the promotion of continence, the proper use of continence-care products, appropriate toileting routines, and the evaluation of each resident's care plan to ensure the continence program is being managed effectively, that individualized continence care programs will be based on each resident's needs and will be developed to maximize independence, comfort and dignity and reviewed quarterly or after any significant change in health status; and that individual care plans will be developed including a voiding monitoring record .

The licensee failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. [s. 6. (2)]

12. The care plan for resident #2639 was reviewed for information related to continence and toileting and under the problem of "Sleep and Rest" it included an intervention of "Toilet before bedtime and establish a toileting routine during the night". Staff #207 reported to Inspector #196 on July 23, 2014, resident #2639 wears a pull up brief during the day and is continent of urine and during the night, a night brief is used and changed and the resident is not toileted during the night unless the resident wants to have a bowel movement. In addition, staff #205 told Inspector #580 that this resident is incontinent at night and wears a brief and soaks the bed twice at night. The care plan identified the intervention of establishing a toileting routine during the night shift and direct care staff reported that resident #2639 is not toileted during the night shift. As a result, resident #2639 is incontinent of urine during the night despite being mostly continent during the day time.

The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

13. The health care record for resident #2623 was reviewed and the progress notes identified falls had occurred over four months. The "Morse Fall Scale" that was completed after each of these three falls, scored the resident as being at high risk for falls.

The licensee's Policy B3-22 titled "Falls Prevention Plan" was reviewed and it included "8. Update care plan and make recommendations to prevent further falls" and that the "care plan must be evaluated on a regular basis to ensure that it meets the client/residents needs and is updated post fall".

The current care plan as found in the binder had not been revised and remained unchanged despite resident #2623's three falls.

The licensee 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. [s. 6. (10) (b)]

14. The current care plan for resident #2639 was reviewed by Inspector #196 on July 22, 2014. Under the problem listing of "Functional ROM" it noted a "mechanical lift in room" and that this resident is a "two person assist". On the last page of the care plan there is a undated hand written note that reads "overbed lift ready to use, batteries changed by staff #205." An interview was conducted with staff #206 and it was reported that resident #2639 is a one person assist with transferring and the resident can pull themselves up and therefore the care plan is not accurate as neither a mechanical lift nor an overbed lift is not being used any longer. In addition, the most recent MDS assessment identifies the resident as a one person physical assist for transfers.

An interview was conducted with staff #201 who stated that the Lead RPN updates care plans following quarterly and annual reviews. The written plan of care was not revised when the care needs of resident #2639 had changed.

The licensee 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. [s. 6. (10) (b)]

15. On July 22, 2014 Inspector #580 reviewed the care plan for resident #2643 related to bladder due to absence of routine, poor hygienic techniques and toileting related to absence of routine, cognitive impairment, use of laxative/cathartic.

On July 17, 2014 staff #201 told Inspector #580 that the Lead RPN completes the entire care plan, prints it, asks the Home's RPNs and PSWs for input and that the Lead RPN and multidisciplinary committee try to update the care plan quarterly. On July 17, 2014 the DON told Inspector #580 that care plans are complete in MED e-Care from RAP triggers and that care plans are revised when there is a change in a resident's condition. On July 22, 2014 staff #201 told Inspector #580 that resident #2643 refuses to go to the bathroom, states that it is the staff's job to change the resident, and had an assessment done but with no follow-through related to information given to the care plan. On July 22, 2014 staff #205 told Inspector #580 that they are not aware of what is in resident #2643's care plan when asked about the resident's care information relating to continence and toileting issues but stated the following, the resident is incontinent at night; needs excessive direction when to toilet; is toileted every two hours; the resident wears a different size brief from the pull up so that the brief does not fall down; the resident does not have the "know" to know they have to go to the bathroom or when to go when on the toilet and that the resident is incontinent when lying down. Inspector #580 did not find this information documented in the care plan or elsewhere in the resident chart. On July 22, 2014 staff #206 told Inspector #580 that they believed resident #2643's care plan has the following information relating to continence and toileting issues: the resident is to be toileted before and after meals and in the morning and evening; the resident is ambulatory but requires reminders to go to the washroom; and that the resident wears a brief day and night. Inspector #580 did not find this information documented in the care plan or elsewhere in the resident chart.

On July 22, 2014 Inspector #580 reviewed the Home's McCausland Hospital Policy/Procedure on LTC-Continence Program B3.15 dated February 2014 which indicates:
-continence management includes assessment for incontinence, the promotion of continence, the proper use of continence-care products, appropriate toileting routines, and the evaluation of each resident's care plan to ensure the continence program is being managed effectively
-individualized continence care programs will be based on each resident's needs and will be developed to maximize independence, comfort and dignity and reviewed

quarterly or after any significant change in health status.

The licensee 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, care set out in the plan has not been effective. [s. 6. (10) (c)]

16. On July 22, 2014 Inspector #580 reviewed the care plan for resident #2639 related to:
a) Bladder due to impaired mobility and inadequate fluid intake, change during night if possible, use incontinent products at night, disposable/reusable diapers –large, respond to toileting requests as soon as possible and do not toilet by self use a mechanical lift;
b) b) Toileting due to cognitive impairment, decrease strength in lower extremities, poor balance with interventions of call bell to be within reach, and encourage client to use to call staff, client uses a soaker pad at night, disposable/reusable diapers – small/medium/large size and needs help with clothing and underwear.

On July 22, 2014 Inspector #580 reviewed resident #2639’s Bowel and Bladder Assessment which indicated that the formerly worsening bladder problem had become stable. On July 17, 2014 the DON told Inspector #580 that care plans are revised when there is a change in a resident’s condition. On July 17, 2014 staff #201 told Inspector #580 that the Lead RPN and multidisciplinary committee try to update the care plan quarterly.

On July 22, 2014 staff #201 told Inspector #580 that resident #2639 is incontinent at night, asks to go to the bathroom during the day, wears a continence product and has had no assessment to decide whether wearing a product is needed however the PSWs decided that the resident needed a continent product. On July 22, 2014 staff #205 told Inspector #580 that resident #2639’s care plan has the following information relating to continence and toileting issues, is incontinent at night and wears a full brief, soaks the bed twice at night, wears pull ups during the day, will ask during the day to go to the toilet, uses a lift with a bar for transfer to the toilet, does not get certain beverages before bedtime and is toileted after supper and before bed. On July 22, 2014 staff #206 told Inspector #580 that resident #2639 care plan has the following information relating to continence and toileting issues a brief at night, pull ups during the day, and can go to the bathroom on their own.

On July 22, 2014 Inspector #580 reviewed the Home’s McCausland Hospital

Policy/Procedure on LTC-Continence Program B3.15 dated February 2014 which indicates that the residents shall receive care and services consistent with his/her care plan, that continence management includes assessment for incontinence, the promotion of continence, the proper use of continence-care products, appropriate toileting routines, and the evaluation of each resident's care plan to ensure the continence program is being managed effectively, that individualized continence care programs will be based on each resident's needs and will be developed to maximize independence, comfort and dignity and reviewed quarterly or after any significant change in health status; and that individual care plans will be developed including a voiding monitoring record .

The licensee 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, care set out in the plan has not been effective. [s. 6. (10) (c)]

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 home's McCausland Hospital Policy/Procedure on LTC-Continence Program B3.15 dated February 2014 is complied with, to ensure that there is a written plan of care for each resident, specifically residents #2643, #2626, #2623, #2639, that sets out clear directions to staff and others who provide direct care to the resident; to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, specifically residents #2643 and #2639; to ensure that the care set out in the plan of care is provided to the resident, specifically to resident #2639, as specified in the plan; 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, specifically for residents #2623 and # 2639; and to ensure that the resident, specifically for residents #2643 and #2639, is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: 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. On July 22, 2014 Inspector #580 reviewed the Wilkes Terrace Resident Assessment Database for resident #2626, and found only two separate individual assessments done by the physiotherapist and the dietitian which included: minimal exercise class, minimal walking class, senior drop in, no short term goals and no long term goals. On June 17, 2014 Inspector #580 reviewed resident #2626's care plan which indicates the following interventions for "activities": check activity calendar daily for appropriate program; explain to client what is about to happen when at activities; have client increase activity level gradually; occasionally participates in Recreational Therapy with "+++" encouragement; provide consistency with staffing, ensuring that those staff that have developed a rapport with the client are assigned to them; and regularly encourage client to attend activities.

On July 18, 2014, Inspector #580 reviewed the Home's Activity Calendar over a month long period, the Fine Motor Activity Class and the Gross Motor Activity Class which indicated that resident #2626 had participated in few Fine Motor Activity Classes, few Gross Motor Activity Classes, no other records of participation in the 42 other activities and for a total of 0.7% participation in activities.

On July 22, 2014 staff #201 told Inspector #196 that residents are asked about interests and activities on admission in the Resident Admission Assessment. On July 22, 2014 the DON confirmed to Inspector #580 that the CPM does not participate in the resident admission assessment, does not participate in care planning and does not keep documentation regarding the initial resident meeting or subsequent meetings. On July 22, 2014 CPM told Inspector #580 that the CPM does not participate in the activity portion or any other part of the resident admission assessment, the CPM meets the newly admitted resident and invites them to participate in activities, provides them an activity calendar and asks them what their interests are but does not document this or review the chart or the care plan. On July 17, 2014 the CPM, told Inspector #580 that: the CPM is not sure of the resident's

diagnosis; resident #2626 likes to sit in their room and watch movies and doesn't want to participate in activities; the CPM has organized a "drive-in movie night at the Home" that the resident participates in monthly; and the CPM does weekly menu choice meetings with the resident.

On July 23, 2014 Inspector #580 reviewed the Home's Admission Assessment policy B1 dated February 2014 which indicates that the initial plan of care will address psychological well-being, cultural, special and religious preferences and that these will be documented, that the care will be based on the initial admission assessment including needs and preferences, that all staff will be kept aware of the contents of the plan and have convenient and immediate access to it, that the plan of care will be reviewed and reassessed by the health care team when the needs of the resident change, or when the care set out in the plan is no longer necessary or if the care is not effective.

The licensee did not 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. [s. 30. (2)]

2. On June 17, 2014 Inspector #580 reviewed resident #2639's care plan which indicates no interventions for "activities" related to low activity tolerance and personal choice.

On July 22, 2014 Inspector #580 reviewed the Wilkes Terrace Resident Assessment Database for resident #2639 and found that a multidisciplinary team did not assess the resident for activities. On July 22, 2014 staff #201 told Inspector #196 that residents are asked about interests and activities on admission in the Resident Admission Assessment. On July 22, 2014 the CPM told Inspector #580 that the CPM does not participate in the activity portion or any other part of the resident admission assessment, that the CPM meets the newly admitted resident and invites them to participate in activities, provides them an activity calendar and asks them what their interests are but does not document this or review the chart or the care plan. On July 22, 2014 the DON confirmed to Inspector #580 that the CPM oversees the activity program but does not participate in the resident admission assessment, does not do charting in the resident's chart, does not participate in care planning and does not keep documentation regarding the initial resident meeting or subsequent meetings.

The licensee did not 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. [s. 30. (2)]

3. On July 23, 2014, mid-morning, Inspector #580 observed resident #2643 lying on the bed fully clothed staring at the ceiling.

On June 17, 2014 Inspector #580 reviewed resident #2643’s care plan effective February 19, 2014 which indicates the following interventions for “activities” related to apathy, cognitive impairment and anxiety: activity as tolerated; determine client’s preferred activities; have client increase activity level gradually; and make sure client is comfortably seated at activities. On July 22, 2014 Inspector #580 reviewed the Wilkes Terrace Resident Admission Assessment for resident #2643, and noted they were interested in a variety of activites.

On July 17, 2014 the CPM, confirmed to Inspector #580 that the CPM is not sure of resident #2643’s diagnosis; that resident #2643 does not want to participate in activities; and that the CPM has tried to encourage resident #2643 to participate in activities but the resident does not participate. On July 22, 2014 the CPM told Inspector #580 that the CPM does not participate in the activity portion or any other part of the resident admission assessment and the CPM meets the newly admitted resident and invites them to participate in activities, provides them an activity calendar and asks them what their interests are but does not document this or review the chart or the care plan. On July 22, 2014 the DON confirmed to Inspector #580 that the CPM oversees the activity program, that the CPM does not participate in the resident admission assessment, does not do charting in the resident’s chart, does not participate in care planning and does not keep documentation regarding the initial resident meeting or subsequent meetings.

On July 23, 2014 Inspector #580 reviewed the Home’s Admission Assessment policy B1 dated February 2014 which indicates that the initial plan of care will address psychological well-being, cultural, special and religious preferences and that these will be documented, that the care will be based on the initial admission assessment including needs and preferences, that all staff will be kept aware of the contents of the plan and have convenient and immediate access to it, that the plan of care will be reviewed and reassessed by the health care team when the needs of the resident change, or when the care set out in the plan is no longer necessary or if the care is not effective.

The licensee did not 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. [s. 30. (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 any actions taken with respect to a resident, specifically residents #2626, #2643, and #2639, under the Home's Recreation and Social Activities program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

s. 122. (1) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and O. Reg. 79/10, s. 122 (1).
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122 (1).

Findings/Faits saillants :

1. During a review of the contents of the medication room and cart on July 21, 2014 at 1610hrs, several containers of over the counter (OTC) medication were noted. Staff #203 confirmed to the inspector that family members have purchased these OTC medications for the residents and the DON reported that OTC meds can be brought in to the home by family, that the MD is made aware and either orders it or discontinues the medications. The DON also stated that it was not clear why the Home's pharmacy provider, doesn't supply these for the residents.

Inside the medication cart there was a container of Cranberry Complex 500mg, one bottle of Tylenol Arthritis and a bottle of Co-enzyme 200mg for resident #2630, a box of Reactine and Nizoral for resident #2644, resident #2624 had a bottle of Lambert syrup (for coughs) and there was a bottle of Gaviscon for resident #2640.

The licensee failed to ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug, (b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. [s. 122. (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 no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug, has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario, to be implemented voluntarily.

WN #4: 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. During a review of the contents of the medication cart on July 21, 2014, a bottle of Koffex DM 3mg/ml labeled with resident #2630's name was noted to be expired 06/14.

The licensee failed to ensure that, (a) drugs are stored in an area or a medication cart, (iv) that complies with manufacturer's instructions for the storage of the drugs; [s. 129. (1) (a)]

2. On July 15, 2014 during Stage 1 resident observations, Inspector #580 observed one Polysporin tube and one Preparation H in the washroom of resident #7658.

Every licensee of a long-term care home shall ensure that, (a) drugs are stored in an area or a medication cart, (ii) that is secure and locked. [s. 129. (1) (a)]

3. On July 21, 2014 at 1610hrs, the medication cart contents were reviewed by inspector #196 and it was determined that several controlled substances were not stored in a separate locked area within the locked medication cart. Specifically, in the drawer, there were medication pouches containing controlled substances for 6 residents. All of these controlled substances were in the medication cart in the drawers and not in a separate locked area.

The licensee failed to ensure that, (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. [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 complies with manufacturer's instructions for the storage of the drugs, to ensure that, drugs are stored in an area or a medication cart, that is secure and locked, 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 #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. On July 21, 2014 at 1710 hrs, Inspector #196 observed staff #203 prepare a syringe for administration to resident #1349. Staff #203 then asked staff #206 to witness the amount of medication in the syringe and stated to the staff a specific amount of medication for resident #1349 and staff #206 confirmed that it was correct. Inspector #196 looked over at the MAR book that was opened on the medication cart and noted that the medication had administration times of 0800 and 2100 hrs and not 1700hrs. The Inspector observed staff #203, go around the end of the medication cart to approach the resident at the dining table within 1.5 meter from the medication cart. At that time, Inspector #196 questioned staff #203 as to the times that the medication is to be administered. Staff #203 then came back to the cart and noted the administration times of 0800 and 2100 hrs. Stated "oh, this was an error", then stated " I checked the orders this morning and the orders had been changed since I worked last". Inspector #196 intervened and prevented the staff member from administering the medication at the incorrect time to the resident.

The physician's orders dated July 18, 2014 were reviewed and noted 12 units h.s. of the same medication for resident #1349. In addition, the current MAR (medication administration record) identified the medication administration was to be 0800 hrs and 2100 hrs.

The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (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 drugs, specifically insulin, are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: 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).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. On July 23, 2014 Inspector #580 reviewed the Home’s following policies:
-Admission of a New Resident policy A1.6 dated July 2013 which indicates that all required admission assessments will be completed including immunization status by the admitting nurse.
-Resident Imminization (spelt incorrectly) and Screening policy dated April 2014 indicates that all residents admitted to the Home are to have a two-step TB skin test done within 14 days of admission unless documented evidence of screening within 90 days is available.

On July 22, 2014, residents’ charts where reviewed residents #3448, #1830, #7658 and #1340 and two charts did not have the documentation showing screening for tuberculosis:
-The chart for resident #3448, included an Immunization History and Consent Record on chart, a note clipped to top form states "family is checking". The two-step was not done within the 14 days.
-the chart for resident #1340, included an Immunization History and Consent Record on the chart, with a signed consent, but the 2 Step Tuberculin test not ordered on LTC General Admission Order Set. There was no chest xray ordered, no evidence of history of TB, the Admission History shows no reference to TB or TB testing. Staff #203 confirmed that that the TB skin test was not ordered or and not administered.

The licensee failed to ensure that each resident admitted to the home is screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. [s. 229. (10) 1.]

2. On July 23, 2014 Inspector #580 reviewed the Home's following policies:
-Admission of a New Resident A1.6 dated July 2013 which indicates that all required admission assessments will be completed including immunization status by the admitting nurse.
-Resident Imminization (Immunization) and Screening dated April 2014 indicates that residents will be offered immunization against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
-Immunization policy dated May 2013 indicates that Tetanus and diphtheria will be given if not given in the last ten years and the Pnuemovax (Pneumovax) shots will be given if not previously given.
-Pneumococcal Vaccines dated April 2013 indicates that all residents will be asked for their vaccination records which will be placed onto their charts for reference.

On July 22, 2014 residents' charts #3448, #7658, #1830 and #1340 were reviewed and two residents did not have documentation confirming immunization as per the publicly funded immunization schedules posted on the Ministry website and the Home's policies.
-The chart for resident #1830, indicates an Immunization History and Consent Record on the chart, that the Tetanus/Diphtheria consent is signed, is ordered by the physician but there is no evidence to verify that immunization had been given or received within the last 10 years.
-The chart for resident #1340 indicates that an Immunization History and Consent Record on chart, that the consent is signed but immunization history is not complete. Staff #201 was unable to confirm that the test had been administered. On July 23, 2014 the DON confirmed that the pneumoccocal vaccine is offered on admission unless the resident is immuno-compromised then could be offered every 5 years but this has never happened.

The licensee failed to ensure that the residents are offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. [s. 229. (10) 3.]

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 implementation of the infection control program, to ensure that each resident admitted to the home is screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee, and to ensure that the residents are offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website, to be implemented voluntarily.

WN #7: 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 health care record for resident #2623 was reviewed and the progress notes identified falls had occurred over a four month period. The "Morse Fall Scale" that was completed after each of these three falls, scored the resident as being at high risk for falls.

The licensee's Policy B3-22 titled "Falls Prevention Plan" was reviewed and it included "8. Update care plan and make recommendations to prevent further falls" and that the "care plan must be evaluated on a regular basis to ensure that it meets the client/residents needs and is updated post fall".

The current care plan as found in the binder had not been updated after these falls and remained unchanged despite resident #2623's three falls.

The licensee failed to ensure that the 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 is complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. The health care records for resident #2643 were reviewed on July 17, 2014. The progress notes identified a total of four falls and the Morse Fall scale done post falls determined the resident to be a high risk for falls. The care plan was reviewed and it did not include reference to resident #2643's risk for falls nor did it include strategies or interventions aimed at reducing the incidence of falls. The licensee's policy/procedure #B3-22 titled "Falls Prevention Plan" was reviewed and included specific interventions and strategies that could be utilized to reduce falls and these were not incorporated into resident #2643's plan of care. The licensee did not comply with their falls program.

The licensee failed to ensure that, 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, (b) is complied with. [s. 8. (1) (a),s. 8. (1) (b)]

3. On July 22, 2014 Inspector #580 reviewed the care plan for resident #2643 related to:
a) Bladder due to absence of routine, poor hygienic techniques
-provide pericare after each incontinence
-use disposable/reusable diapers – small/medium/large
b)Toileting related to absence of routine, cognitive impairment, use of laxative/cathartic
-call bell to be within reach, and encourage client to use to call staff
-disposable/reusable diapers – small/medium/large size
-routine toileting by staff.

On July 17, 2014 staff #201 told Inspector #580 that:
-the multidisciplinary committee of the physiotherapist, the dietitian, the Lead RPN and

the CPM meet weekly to discuss the resident including the six week , annual and family care conferences;
-the Lead RPN completes the entire care plan, prints it, asks the Home's RPNs and PSWs for input, updates the plan in writing, and places the individual care plans into one binder in room behind the nursing station for all staff to use;
- the physiotherapist, the dietitian and the CPM do not input information electronically into the MED e-care care plan or onto the printed copy; and
-the Lead RPN and multidisciplinary committee try to update the care plan quarterly.

On July 17, 2014 the DON told Inspector #580 that care plans are complete in MED e-care from RAP triggers and that care plans are revised when there is a change in a resident's condition.

On July 22, 2014 staff #201 told Inspector #580 that resident #2643 refuses to go to the bathroom, states that it is the staff's job to change the resident and that the resident had an assessment done but with no follow related to information given to the care plan. On July 22, 2014 staff #205 told Inspector #580 that they are not aware of what is in resident #2643's care plan when asked about the resident's care information relating to continence and toileting issues but stated the following: the resident is incontinent at night, needs excessive direction when to toilet, is toileted every two hours, the resident wears a different size brief from the pull up so that the brief does not fall down; and the resident does not "know" that they have to go to the bathroom or when to go when on the toilet and that the resident is incontinent when lying down. On July 22, 2014 staff #206 told Inspector #580 that they think that resident #2643's care plan has the following information relating to continence and toileting issues: the resident is to be toileted before and after meals and in the morning and evening, the resident is ambulatory but requires reminders to go to the washroom and that the resident wears a brief day and night.

On July 22, 2014 Inspector #580 reviewed the Home's McCausland Hospital Policy/Procedure on LTC-Continence Program B3.15 dated February 2014 which indicates:
-the residents shall receive care and services consistent with his/her care plan
-continence management includes assessment for incontinence, the promotion of continence, the proper use of continence-care products, appropriate toileting routines, and the evaluation of each resident's care plan to ensure the continence program is being managed effectively
-individualized continence care programs will be based on each resident's needs and

will be developed to maximize independence, comfort and dignity and reviewed quarterly or after any significant change in health status.
-individual care plans will be developed including a voiding monitoring record.

The licensee failed to ensure that the Home's Continence Program is complied with. [s. 8. (1) (a),s. 8. (1) (b)]

4. On July 22, 2014 Inspector #580 reviewed the care plan for resident #2639 related to:
a) Bladder due to impaired mobility and inadequate fluid intake, change during night if possible, use incontinent products at night, disposable/reusable diapers –large, respond to toileting requests as soon as possible and do not toilet by self use a mechanical lift;
b) Toileting due to cognitive impairment, decrease strength in lower extremities, poor balance with interventions of call bell to be within reach, and encourage client to use to call staff, client uses a soaker pad at night, disposable/reusable diapers – small/medium/large size and needs help with clothing and underwear.

On July 17, 2014 the DON told Inspector #580 that care plans are revised when there is a change in a resident's condition. On July 17, 2014 staff #201 told Inspector #580 that the Lead RPN and multidisciplinary committee try to update the care plan quarterly.

On July 22, 2014 staff #201 told Inspector #580 that resident #2639 is incontinent at night, asks to go to the bathroom during the day, wears a continence product and has had no assessment to decide whether wearing a product is needed however the PSWs decided that the resident needed a continent product. On July 22, 2014 staff #205 told Inspector #580 that resident #2639's care plan has the following information relating to continence and toileting issues, is incontinent at night and wears a full brief, soaks the bed twice at night, wears pull ups during the day, will ask during the day to go to the toilet, uses a lift with a bar for transfer to the toilet, does not get certain beverages before bedtime and is toileted after supper and before bed. On July 22, 2014 staff #206 told Inspector #580 that resident #2639 care plan has the following information relating to continence and toileting issues a brief at night, pull ups during the day, and that can go to the bathroom on their own.

On July 22, 2014 Inspector #580 reviewed the Home's McCausland Hospital Policy/Procedure on LTC-Continence Program B3.15 dated February 2014 which

indicates that the residents shall receive care and services consistent with his/her care plan, that continence management includes assessment for incontinence, the promotion of continence, the proper use of continence-care products, appropriate toileting routines, and the evaluation of each resident's care plan to ensure the continence program is being managed effectively, that individualized continence care programs will be based on each resident's needs and will be developed to maximize independence, comfort and dignity and reviewed quarterly or after any significant change in health status; and that individual care plans will be developed including a voiding monitoring record .

The licensee failed to ensure that the Home's Continence Program is complied with. [s. 8. (1) (a),s. 8. (1) (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. During the stage one process of the RQI, resident # 2634, #2639 and #2643 were observed to have either one or two upper bed rails elevated on their respective beds. According to staff #207 most of the side rails on the resident beds are kept elevated as the controls for the bed are on the rail. On July 22, 2014, an interview was conducted by inspector #196 with the DON regarding side rail assessments and it was determined that the licensee does not assess for use of bed rails.

The licensee failed to ensure that where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident. [s. 15. (1) (a)]

WN #9: 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:
10. Health conditions, including allergies, pain, risk of falls and other special needs. 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:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The health care records for resident #2643 were reviewed for information regarding falls and risk for falls. The Progress Notes identified falls had occurred over a five month period and the Morse Fall scale that was completed after these incidents noted the resident to be a high risk for falls. The care plan was reviewed and did not include reference to resident #2643's risk for falls and did not contain interventions aimed at reducing fall incidents.

The licensee failed to ensure that the plan of care is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 10. Health conditions, including allergies, pain, risk of falls and other special needs. [s. 26. (3) 10.]

2. During the stage one process of the RQI, it was identified that resident #2634 had been recently ordered antibiotics for dental swelling and arrangements were made for further dental treatment. The care plan for resident # 2634 as found in the care plan binder was obtained and reviewed and there was no reference to this resident's dental and oral status or oral hygiene needs.

The licensee failed to ensure that a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 12. Dental and oral status, including oral hygiene. [s. 26. (3) 12.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident’s substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. During stage one observations on July 15, 2014, resident #2626 was noted to have a loose top denture that moved when speaking and also the resident reported that the loose denture made it difficult to chew food. An interview was conducted with staff #207 on July 23, 2014 at 10:35 hours and it was reported that it is "hard to understand her as the upper denture keeps falling, probably has difficulty eating as well as a result of the loose denture". Staff #201 and staff #204 both reported no annual dental assessments are offered to residents.

The licensee failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, (c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. [s. 34. (1) (c)]

2. The MDS assessment identified resident #2634 to have either "broken, loose or carious teeth". According to staff #201 on July 22, 2014, annual dental assessments are not offered to residents of the home and that if issues arise the SDM/POA may be contacted for them to arrange appointments as required.

The licensee failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, (c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. [s. 34. (1) (c)]

3. On July 15, 2014, resident # 2644 reported to the inspector that they were having difficulty with their denture and that a sore had developed. According to an interview conducted with staff #201 on July 22, 2014, no annual dental assessments are offered to residents of the home and if issues arise the SDM/POA may be contacted for them to arrange appointments as required.

The licensee failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, (c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. [s. 34. (1) (c)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. On July 15, 2014 during Stage 1 resident observations, Inspector #580 observed improperly labelled Infazinc and Vitarub creams in resident bathrooms including shared bathrooms:
129-W - Resident #2623 - two unlabelled Infazinc;
130-E - Resident #2636 - two unlabelled Infazinc;
130-W - Resident #2638 - three unlabelled Infazinc, one Vitarub;
128-1 - Resident #2639 - one unlabelled Vitarub.

The licensee failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, (a) labelled within 48 hours of admission and of acquiring, in the case of new items [s. 37. (1) (a)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. On July 15, 2014 at 1840, Inspector #580 observed staff # 204 spray and wipe resident #2631’s chair and table with A3 after the resident left the dining room upon completing the supper meal. Staff #204 stated that the resident has a specific type of infection which has been difficult to treat and that part of the Home's isolation precautions require staff to spray and wipe after the resident leaving the dining room. On July 23, 2014, when asked by Inspector #580, staff #211 described the automatic chemical dispensing system that is used to prepare the solution for the A3 disinfecting liquid. On July 23, 2014 staff #212 told Inspector #580 that the disinfectant solution A3 is to be sprayed on to disinfect the table and chair after resident #2631 leaves the dining room after meals and that the solution should stay on the surface for 10 minutes to be effective but did not know where the policy for this disinfection procedure was kept and confirmed the spray bottle did not contain the time effective information. On July 23, 2014 staff #207 told Inspector #580 that they were not aware of the length of time the A3 solution should remain on the table and chair surface in order to correctly disinfect before being wiped off, and also did not know where to find a policy or procedure or other information on how to do the procedure correctly. On July 23, 2014 the DON told Inspector #580 that the staff had been given an in-service in December 2013 but did not have printed information or directive on the isolation procedures, on the table and chair disinfection procedure or an updated correct policy or procedure.

The licensee failed to ensure that the infection prevention and control program includes measures to prevent the transmission of infections. [s. 86. (2) (b)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. O. Reg. 79/10, s. 114 (2).

Findings/Faits saillants :

1. On July 22, 2014, an interview was conducted with the DON regarding the licensee's written policies and protocols for the destruction and disposal of all drugs used in the Home. It was reported that the written policies are as in the pharmacy provider's binder in the medication room and an additional policy titled "Medication Administration C1" was provided.
An interview was conducted with staff #201 and it was reported that drugs that are to be destructed are sent back to the pharmacy via Purolator shipment and that the pharmacy then does the destruction. A review of these written policies was undertaken by Inspector #196 and neither policy clearly identifies the procedures in which all drugs, controlled substances and not controlled, are to undergo destruction and disposal.

The licensee failed to ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. [s. 114. (2)]

WN #14: 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. On July 15, 2014 during Stage 1 resident observations, Inspector #580 observed one clear jar with white cream and a label stating Clotriderm in the room of Resident #2638. The jar had no directions for use.

The licensee failed to 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. [s. 126.]

WN #15: 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. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

1. During an interview with the DON on July 23, 2014 it was reported that non-controlled substances are sent back to the pharmacy service provider via Purolator shipment and are destroyed by them. There is no drug destruction done on site at the long-term care unit by a member of the nursing staff and another staff member. According to the DON, the pharmacy service provider has asked that the medications be sent back to them for destruction.

The licensee failed to ensure that drug are destroyed by a team acting together and composed of, (b) in every other case, (not a controlled substance) (i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and (ii) one other staff member appointed by the Director of Nursing and Personal Care. [s. 136. (3) (b)]

Issued on this 31st day of October, 2014

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