Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 13, 2015	2015_339617_0020	021574-15	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

SHEILA CLARK (617), JENNIFER KOSS (616)

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): September 14, 15, 16, 17, 18, 21, 22, and 23, 2015.

During the course of the inspection, the inspector(s) spoke with residents and their families, the Chief Nursing Officer (CNO), the acting Chief Nursing Officer (ACNO), Resident Assessment-Instrument Minimum Data Set (RAI-MDS) Coordinator, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Community Program Manager (CPM), Housekeeping Aides (HAs), Laundry Aides (LAs), Registered Dietitian (RD), the Nutrition Manager (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:
Admission and Discharge
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Recreation and Social Activities
Residents' Council
Snack Observation

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

10 WN(s)
5 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for residents #002, #003, #006, #007, #008, and #009 that set out, clear directions to staff and others who provide direct care to the residents regarding certain areas of care provision.

Inspector #617 reviewed the health care records for resident #002 which identified that the quarterly Resident Assessment Instrument-Minimum Data Set (RAI-MDS) assessment dated June 12, 2015, indicated multiple episodes of bladder incontinence that required a scheduled toileting plan which was no change from the prior assessment.

Inspector #617 reviewed the health care records for resident #002 which identified a care plan for toileting last updated on January 20, 2015, which indicated that the resident was to be toileted routinely by staff and required cueing prior to meals/activities/outings for toileting.

On September 17, 2015, at 1550hrs, inspector #617 interviewed resident #002 who reported that they toileted independently, were continent and did not receive assistance from the staff to toilet.

On September 17, 2015, at 1349hrs, inspector #617 interviewed S #104, who confirmed that they didn't provide cueing to resident #002 to toilet because they were independent and continent.

S #104 reviewed with inspector #617, the kardex dated June 9, 2015, and the care plan dated January 20, 2015, for resident #002; and confirmed that interventions for bladder incontinence did not reflect the current care and condition of the resident. S #104 reported that neither the kardex or the care plan indicated that resident #002 used a specific incontinent product, and did not require cueing or assistance to toilet.

2. On September 18, 2015, at 1045hrs, inspector #617 observed two quarter bed rails engaged in the up position at the top of resident #003's bed.

Inspector #617 reviewed the health care records for resident #003 which identified that the quarterly RAI-MDS assessment dated August 28, 2015, indicated the use of bed rails during the assessment period.

On September 18, 2015, inspector #617 interviewed S #112 who reported that resident #003 was independent when transferring in and out of bed and the quarter bed rails in the up position at the top of the bed, did not impede resident #003 from getting out of bed.

On September 18, 2015, inspector #617 reviewed the care plan for resident #003 dated January 1, 2015, which did not indicate the use of quarter bed rails.

Inspector #617 and S #112 reviewed the care plan for resident #003, and S #112 confirmed that the use of bed rails was not indicated in the care plan and that staff put the bed rails in the up position for all residents in the home to maintain safety.

The home assessed the need and were providing the use of bed rails to resident #003. However the use of bed rails was not indicated in the care plan for staff direction.

3. On September 18, 2015, at 0942hrs, and at 1059hrs, inspector #617 observed two quarter bed rails engaged in the up position at the top of resident #006's bed.

Inspector #617 reviewed the health care records for resident #006 which identified that the quarterly RAI-MDS assessment dated June 4, 2015, indicated the use of other types

of bed rails during the assessment period.

On September 18, 2015, at 1035hrs, inspector #617 interviewed S #112 who reported that resident #006 was totally independent with transferring in a out of bed and the quarter bed rails in the up position did not impede resident #006 from getting out of bed on their own. S #112 stated that both bed rails were up for resident #006 to maintain safety and for the use of the bed controls.

On September 24, 2015, inspector #617 reviewed the care plan for resident #006 dated July 2, 2015, which did not indicate the use of quarter bed rails as an intervention.

Inspector #617 and S #112 reviewed the care plan for resident #006 and S #112 confirmed that the use of side rails was not indicated in the care plan and that staff put up the quarter rails for all residents in the home to maintain safety.

The home assessed the need and were providing the use of bed rails to resident #006. However the use of the bed rails was not indicated in the care plan for staff direction.

4. On September 18, 2015, at 0943hrs, inspector #617 observed resident #009 lying in bed with both quarter bed rails engaged in the up position at the top of the bed.

Inspector #617 reviewed the health care records for resident #009 which identified that the quarterly RAI-MDS assessment dated August 22, 2015, indicated the use of bed rails during the assessment period.

On September 23, 2015, inspector #617 interviewed S #112 who reported that resident #009 was independent when transferring in and out of bed and used the bed rails to promote the transfer. S #112 reported that the bed rails in the up position did not impede resident #009 from getting out of bed.

On September 18, 2015, inspector #617 reviewed the care plan for resident #009 dated November 2, 2014, which indicated the use of one bed rail for emotional support while in bed.

Inspector #617 and S #112 reviewed the care plan for resident #009 and S #112 confirmed that the use of both side rails for bed mobility and transferring was not indicated in the care plan and that staff put up the quarter rails for all residents in the home.

The home assessed the need and were providing the use of two bed rails to resident #009. However the use of two bed rails for assistance with mobility was not indicated in the care plan for staff direction.

5. Inspector #616 reviewed resident #003's care plan last updated on February 26, 2015, which referred to the resident's need for a different incontinent product than what was indicated in the kardex last updated on June 9, 2015.

S#-106, S#-111, and S#-101 all confirmed to inspector #616 that the direction for incontinent product sizing available to staff is unclear.

Resident #003's plan of care did not set out clear directions to staff and others who provide direct care.

6. Inspector #617 reviewed the health care records for resident #007 which identified that the quarterly RAI-MDS assessment dated September 6, 2015, indicated daily bladder incontinence which required a scheduled toileting plan.

Inspector #617 reviewed the health care records for resident #007 which identified a care plan for toileting last updated April 14, 2015, indicated that the resident was to be toileted routinely by one or two staff, encouraged to use the call bell, and used incontinent products of no particular size or type.

On September 17, 2015, inspector #617 interviewed S #104 who reported that they provided assistance to resident #007 with toileting every 2 hours. S #104 reported that resident #007 wore two different types of incontinent products during the day and night.

On September 17, 2015, at 1543hrs, inspector #617 observed in the bathroom for resident #007 a supply of different types and sizes of incontinent products. Above the bed there were logos for direction on how to transfer resident safely.

S #104 reviewed the care plan dated April 14, 2015, and the kardex dated June 9, 2015, for resident #007 with inspector #617 and confirmed that interventions for bladder incontinence did not reflect the current care and condition of the resident. S #104 reported that neither the care plan or kardex for resident #007 gave clear direction on the type of incontinent product worn during the day and night and that resident #007 did not use the call bell to call for assistance.

7. Inspector #617 reviewed the health care records for resident #008 which identified that the quarterly RAI-MDS assessment dated July 19, 2015, indicated total incontinence which was no change from the prior assessment.

Inspector #617 reviewed the health care records for resident #008 which identified a care plan for toileting last updated on March 27, 2015, and a kardex last updated on June 9, 2015, which indicated that the resident used an incontinent product, was on specific precautions and that a toileting schedule was not required.

On September 17, 2015, at 1547hrs, inspector #617 interviewed resident #008 who reported that they wore two kinds of incontinent products during the day.

On September 17, 2015, at 1500hrs, inspector #617 interviewed S #113 who confirmed that resident #008 wore two kinds of incontinent products during the day and used an incontinence system when on an outing.

S #113 with inspector #617 reviewed the care plan dated March 27, 2015, and a kardex dated June 9, 2015, for resident #008, and S #113 confirmed that both the care plan and kardex didn't have the information for the incontinent product and system.

8. The licensee has failed to ensure that care set out in the plan of care was based on the fall risk assessment for residents #002 and #004.

Inspector #617 reviewed the health care record for resident #002 which indicated that falls occurred in two consecutive months in 2015.

Inspector #617 reviewed the RAI-MDS quarterly assessment which indicated that resident #002 had experienced a fall in the past 30 days during the assessment period.

Inspector #617 reviewed the health care records for resident #002 which indicated that post fall documentation was completed after each of the falls. The Morse fall score for both falls were at a high level risk and action was required to implement high risk fall prevention interventions.

On September 21, 2015, inspector #617 reviewed the care plan for resident #002 last updated on January 20, 2015, which did not indicate the assessment of high risk for falls and fall prevention strategies to be implemented. Inspector #617 and S #107 reviewed

the care plan for resident #002 and S #107 confirmed that fall prevention interventions were not indicated.

Inspector #617 reviewed the McCausland Hospital policy #LTC last revised June 2012, for falls prevention which indicated that the resident care plan was to be updated after a fall has occurred with interventions to prevent further falls.

The home assessed resident #002 to be at high risk for falls however their plan of care was not based on this assessment.

9. Inspector #617 reviewed the health care record for resident #004 which indicated that a fall occurred.

Inspector #617 reviewed the RAI-MDS quarterly assessment which indicated that resident #004 had experienced a fall in the past 30 days during the assessment period.

Inspector #617 reviewed the health care records for resident #004 which indicated that post fall documentation was completed for the fall. The Morse fall assessment score indicated that resident #004 was a high level risk and action was required to implement high risk fall prevention interventions.

On September 24, 2015, inspector #617 reviewed the care plan for resident #004 last updated on June 15, 2015, which did not indicate the assessment of high risk for falls and fall prevention strategies to be implemented. Inspector #617 and S #107 reviewed the care plan for resident #004 and S #107 confirmed that fall prevention interventions were not indicated.

Inspector #617 reviewed the McCausland Hospital policy #LTC last revised June 2012, for falls prevention which indicated that the resident care plan was to be updated after a fall has occurred with interventions to prevent further falls.

The home assessed resident #004 to be at high risk for falls however their plan of care was not based on this assessment.

10. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #010 as specified in the plan for nutrition and hydration.

Inspector #616 interviewed on September 17, 2015, the Registered Dietitian (RD) S

#109, who reported that resident #010 was a high nutritional risk and ordered a nutritional supplement in April 2015. They stated during the completion of the scheduled quarterly review of the nutritional status for resident #010, they were made aware that the supplement was not being provided to the resident as ordered. They further reported to inspector that the nutritional supplement was not listed on the Medication Administration Record (MAR) for the current month as they have expected.

The inspector's record review of the resident's MAR revealed that the RD's order of April, 2015, was missing from resident #010's MAR for June, July and August. S#-101 also confirmed to inspector on September 17, 2015, that the supplement was not listed in the current MAR, nor was being provided to resident as per order.

Resident #010 did not receive the ordered nutritional supplement for a period of 90 days as per plan of care.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the following:

1. There is a written plan of care for the following residents that sets out, clear directions to staff and others who provide direct care to the residents regarding the following areas of care provision:
Resident #002 – continence care,
Resident #003 – bed rail use, and continence care,
Resident #006 – bed rail use,
Resident #007 – continence care,
Resident #008 – continence care,
Resident #009 – bed rail use.

2. Care set out in the plan of care is based on the fall risk assessment for residents #002 and #004.

3. The care set out in the plan of care is provided to resident #010 as specified in the plan for nutrition and hydration, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan, policy, protocol, procedure, strategy or system regarding hand hygiene and contact isolation, were complied with.

Inspector #617 reviewed the McCausland Hospital policy titled "MacCausland/Wilkes Terrace Policies and Procedures", last updated May 2013, which identified that the McCausland Hospital had existing policies and programs that have been adopted by the Wilkes Terrace site and all staff members are required to know and understand the policies and procedures for both sites.

Inspector #617 reviewed the McCausland Hospital policy #IC-10, titled "Hand Hygiene", last revised on July 2009, which indicated the following :
-Hand hygiene is the responsibility of all individuals involved in health care
-Hand hygiene must be performed before preparing, handling, serving or eating food and after contact with items in patient's environment.

On September 14, 2015, at 1710hrs, inspector #617 was in attendance at the supper meal service in the dining room and observed S #101, remove a dirty plate of food from four residents and then pick up a clean dessert to offer each of the four the residents without cleaning her hands in between. Inspector #617 interviewed S #101 who reported that the home has a policy on hand hygiene that she is expected to follow.

On September 23, 2015, inspector #617 interviewed the Chief Nursing Officer (CNO) who reported that the McCausland Hospital policy and procedure for Infection Control is in effect for Wilkes Terrace and expected that staff are following the policy and procedure.

The home had a policy for hand hygiene that a staff member was observed not to follow exposing residents to risk of infection.

2. Inspector #617 reviewed the McCausland Hospital policy #IC-05 titled "Infection Prevention and Control-Contact Precautions", last updated July 2009, which indicated the following:
-contact precautions are used where transmission of infection occurs when micro organisms are transferred by direct physical contact between an infected or colonized individual or with contaminated equipment or surfaces
-contact precautions are to be used in addition to routine precautions for all patients diagnosed with an antibiotic resistant organism.
-sleeved disposable gowns and gloves are required to enter the patient room. Donning

and doffing of the disposable gowns and gloves in the proper sequence is very important.

On September 14, 2015, during the tour of the home inspector #616 observed contact precaution signs on the doors for two resident rooms. Inspector #617 reviewed the health care records for both residents #008 and #005 which confirmed the use of specific precautions.

On September 23, 2015, at 1043hrs, inspector #617 interviewed S #105 and S #112, who reported that when handling laundry for residents under isolation, they wear a disposal gown and gloves to place it in the blue laundry hamper. Then the laundry hamper sits in the hallway by the tub and shower room to place all residents' laundry into it.

On September 23, 2015, at 1028hrs and on September 18, 2015, at 1233hrs, inspector #617 observed a laundry aide wearing a white lab coat don rubber gloves, remove two blue laundry bags with dirty laundry from the hallway and place them in a mobile bin. The laundry aide was observed to use the same rubber gloves to push the bin down the hallway to the exit door. The laundry aide then removed a glove from one hand to punch the code for the door and leave the unit.

On September 18, 2015, at 1233hrs, inspector #617 interviewed S #114 who reported that they wore the lab coat and rubber gloves as personal protective equipment when handling the contaminated laundry from the resident's room to transport to the laundry room. S #114 reported that the hospital has a policy for handling contaminated laundry and has had training.

On September 23, 2015 inspector #617 interviewed the CNO who reported that all staff are expected to follow the procedure outlined in the policy regarding the use of personal protective equipment for contact precautions. The CNO confirmed that the use of rubber gloves and a lab coat were not following policy.

The home had a policy for contact precautions that staff members were observed not to follow exposing residents to risk of infection.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan, policy, protocol, procedure, strategy or system regarding hand hygiene and contact isolation, are complied with, to be implemented voluntarily.

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #010 with the weight change of 5 per cent of body weight, or more, over one month was assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.

Inspector #616 reviewed resident #010's weight profile and noted a significant weight loss over one month. The Registered Dietitian (RD), S #109, confirmed to inspector #616 on September 17, 2015, that they had not received a referral for the significant weight loss and realized the weight loss the following month when the quarterly assessment was completed.

Inspector reviewed the McClausland Hospital policy #B3.8, titled "Resident Weight Changes" with the Acting DOC on September 24, 2015, who confirmed that staff were to refer significant weight loss as with resident #010 to the dietitian, which had not occurred. As a result of the staff not referring the resident to the RD, resident #010's significant weight change was not assessed using an interdisciplinary approach with actions taken and outcomes evaluated.

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 resident #010 with a weight change of five per cent of body weight, or more, over one month is assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, 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. The licensee had failed to ensure that drugs were stored in an area or a medication cart that complied with manufacturer's instructions for the storage of the drugs.

On September 22, 2015, during inspection of the ward stock supplies in the medication room with S #101, the following drugs were observed by Inspector #616 to be expired:
- one 336 gram bottle of Mucillium powder (expired August 2015),
- two 250 millilitre bottles of Koffex (expired August 2015 and July 2015).

Inspector #616 interviewed S #101 who confirmed that these expired drugs should have been removed from stock and disposed of.

The home's Medication Administration policy dated May 2011, was reviewed by inspector which identified under Safe Storage of Medications that storage were to be complied with the drug manufacturers storage instructions.

On September 23, 2015, inspector #616 interviewed the CNO who confirmed that the expired medications identified should not be available in the drug supply.

The home did not comply with manufacturer's instructions related to storage of the drugs (expiration dates).

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 drug, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee has failed to ensure that the quality improvement and utilization review system required under section 84 of the Act regarding the improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents, was communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.

On September 18, 2015, at 1100hrs, inspector #617 interviewed resident #015, who reported that the licensee had not presented the improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents at the Residents' Council meetings held over the past year.

Inspector #617 reviewed the minutes from the last three meetings dated March 25, 2015, May 27, 2015, and August 5, 2015 which did not identify that the licensee had presented the quality improvement plan to the Resident's Council.

On September 21, 2015, inspector #617 interviewed the CNO, who confirmed that the home had not presented the improvements made through the quality improvement and utilization review system to accommodations, care, services, programs and goods provided to the residents, to the Residents' Council.

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 quality improvement and utilization review system required under section 84 of the Act regarding the improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents, is communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis, to be implemented voluntarily.

WN #6: 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. 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, labelled within 48 hours of admission and of acquiring, in the case of new items.

On September 14, 2015 at 1410hrs, during a tour of the home inspector #616 observed the following unlabelled personal items located in the washroom across from nursing station:
-2 containers of baby powder
-2 bottles of green liquid multipurpose wash
-1 bottle of red soap
-1 can of barbasol shaving cream

Inspector #616 interviewed S #100 who clarified that all residents used the washroom across from the nursing station and confirmed unlabelled products were available for any use by the residents using the washroom.

On September 15, 2015, inspector #616 observed two blue washbasins stacked on the left side of the counter in a shared resident washroom. Inspector #616 observed that neither of the blue wash basins were labelled with resident's name. In both basins, an unlabelled blue comb and black brush with hair were observed.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure a weight monitoring system to measure and record with respect to the weights for residents #004, #014, and #016 was documented on admission and monthly thereafter.

Inspector #617 and #616 conducted a record review and identified the following residents were missing weight data:
-resident #004
-resident #014, and
-resident #016.

Resident #004's admission assessment weight was found to be incomplete by Inspector #616. The inspector reviewed the resident's weight profile which had a documented weight 16 days post admission. In addition, a monthly weight for the month of August 2015 had not been documented. On September 23, 2015, S #107 stated to inspector #616 that resident weights were obtained on date of admission. They confirmed the documentation indicated the resident #004's weight was not obtained on admission, and was not obtained for the month of August.

Inspector #616 reviewed resident #014's weight profile and found weights were not documented for the months of August and September 2015. S#107 confirmed to inspector #616 on September 23, 2015, that the monthly weight had not been obtained for August and September 2015.

Resident #016's weight on admission was not found by inspector #616. The first weight was documented 40 days post admission in the resident weight profile. On September 18, 2015, S #108 reviewed with inspector #616, the resident weight profile binder as well as resident #016's health record including archived medical records for their admission weight. No further documentation record was found and S #108 confirmed that was the first weight obtained post admission for resident #016.

On September 15, 2015, the CNO and S #102 both confirmed the residents' weights were to be obtained on admission, and then monthly as an expectation of the home.

The home did not obtain admission and/or monthly weights for: resident #004, resident #014, and resident #016.

2. The licensee failed to ensure a weight monitoring system was used to measure and record with respect to each resident with body mass index and height upon admission and annually thereafter.

Inspectors #616 and #617 reviewed heights for all residents in the home noting the data was obtained from the resident's admission assessments with the exception of resident #010. Their height on the Resident Admission Assessment was incomplete dating back to 2012. On September 24, 2015, S #110 confirmed to inspector a blank meant it had not been completed.

Inspector #616 reviewed the home's Admission Assessment policy #B1 dated May 2011, which was confirmed by the CNO to have been reviewed in June 2015, noted that height and weight were to be recorded.

On September 15, 2015, inspector #616 interviewed the CNO and S #102, who both confirmed that residents' heights were obtained on admission only.

The home did not measure resident #010's height on admission and annually thereafter, and had not measured heights annually for all other residents.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time.

During inspection of the medication room on September 22, 2015, at 1500hrs, S #101 stated to Inspector #616 that the ward drug supplies observed in the overhead cupboards exceeded a three-month supply.

Inspector reviewed the McCausland Hospital policy #C1 titled, "Medication Administration", last updated May 2011, indicated the following related to drug supplies: "2. No more than a three month supply of medication was to be available".

In an interview with inspector #616 on September 23, 2015, with the CNO who stated that the policy was reviewed in June 2015, and confirmed that the ward stock supply was greater than three months.

The home did not obtain drugs for use in the home based on resident usage.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to the residents receive annual training related to abuse recognition and prevention.

On September 22, 2015, S #101 reported to inspector #616 that education related to abuse and neglect is optional, not mandatory and could not recall when last retrained. S #105 recalled a training session recently but could not recall what, when or how it was provided. S #106 reported to inspector #616 they received training on orientation to the home.

Inspector #616 reviewed the McCausland Hospital policy #PM D2.1-2.9 titled, "In Service Education" which indicated mandatory education consists of but not limited to: Zero Tolerance of Abuse and Neglect.

On September 23, 2015, the CNO confirmed staff education related to prevention of abuse and neglect was mandatory annually with the expectation that staff complete by the end of the year. They provided training records for 2013 and 2015 completed as of the date of inspection. The CNO reported they could not provide the staff sign in sheet to verify retraining in 2014.

The home did not ensure that all staff receive annual training related to prevention of abuse and neglect.

WN #10: 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. (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. The licensee has failed to ensure that residents were offered immunizations against pneumoccocus, tetanus/diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

On September 22, 2015, inspector #617 reviewed the McCausland Hospital policy #14.7 titled, "Resident Immunization and Screening", last updated on April 2014, which indicated that residents will be offered immunization against pneumoccocus, tetanus/diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. The policy identified the following protocols:
-pneumococcal vaccine is indicated for adults greater than 65 years of age and recommended every five years
-tetanus/diphtheria is indicated for all adults and recommended every ten years.

Inspector #617 reviewed the health care records for those residents admitted since August 2014, to the home and determined the following residents had obtained consent but were missing immunizations:
-resident #016 admitted March 26, 2015
-resident #017 admitted August 17, 2015
-resident #018 admitted July 23, 2015.

On September 24, 2015, S #110 reviewed the current and historic health care records as well as inquired at the local health unit for immunization status of resident #016, #017 and #018, and confirmed that they were not immunized on admission.

On September 23, 2015, inspector #617 interviewed CNO who confirmed the expectation that residents on admission are screened for immunizations according to policy.

The home failed to offer immunizations at point of admission according to their own policy and legislation placing residents at risk for infection.

Issued on this 3rd day of December, 2015

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

Original report signed by the inspector.