Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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 18, 2016	2016_493652_0010	027425-16	Resident Quality Inspection

Licensee/Titulaire de permis

601091 ONTARIO LIMITED
429 WALMER ROAD TORONTO ON M5P 2X9

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

CEDARVALE TERRACE
429 WALMER ROAD TORONTO ON M5P 2X9

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

NATALIE MOLIN (652), ARIEL JONES (566), SARAH KENNEDY (605)

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 13, 14, 15, 16, 19, 20, 21, 23, 26, 27 and 28, 2016.

The following critical incident (CI) inspections were conducted concurrently with the RQI: 027588-15 (related to an allegation of abuse); 011242-16 (related to reporting and complaints); 005478-14 (related to transferring); 016122-16 (related to falls prevention); and 005116-15 (related to medication).

The following complaint inspections were conducted concurrently with the RQI: 020202-15 (related to Residents' Bill of Rights); 029848-15 (related to reporting); 032079-15, 011368-16, 024050-16 and 027536-16 (related to an allegation of abuse); and 036264-15 (related to responsive behaviours).

During the course of the inspection, the inspector(s) spoke with the administrator, associate nurse managers, program manager, environmental service manager, nurse managers, unit supervisors, Family Council president, Residents' Council president, registered practical nurses, registered nurses, personal support workers, substitute decision makers and residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council

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

5 WN(s)
2 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 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 any policy put in place is complied with.

A review the Responsive Health Management post-fall assessment policy, revised May 2016, states to only assist a resident up if it has been determined that resident can be moved. Observe for facial expression, guarding, or complaints of pain. If resident is unable to weight bear, do not move resident, call ambulance and prepare for transfer to hospital for assessment.

A review of resident #010's progress notes on an identified date, revealed the resident slipped when the staff was transferring him/her from the bed to the wheelchair.This note revealed personal support workers (PSWs) removed the resident from the floor and transferred him/her back to the wheelchair prior to assessment by the nurse.

An interview with PSW #102 revealed he/she transferred the resident with PSW #101 off the floor using an identified lift before the registered practical nurse (RPN) arrived. An interview with PSW #102 confirmed he/she should have called RPN #103 to assess resident #010 first, as per the home's policy.

An interview with nurse manager (NM) #113 confirmed PSWs #101 and #102 did not ensure resident #010 was assessed by the RPN prior to transferring the resident. NM #113 confirmed the expectation is a registered staff member assesses a resident prior to moving the resident to determine the extent and type of injury and contributing factors that may have caused the fall. [s. 8. (1) (a),s. 8. (1) (b)]

2. A review of the MediSystem narcotic and controlled drugs administration record (N.&C.D.A.R.), index number 04-07-10, revised January 31, 2007, revealed a daily count of all narcotics balance-on-hand must be completed by two nurses at the time of every shift change.

A review of a critical incident report (CIR) from an identified date, revealed NM #113 received discontinued hydromorphone from an identified floor for destruction. When he/she opened the boxes at 1100 hours (h), five ampoules of hydromorphone were broken and empty.

A review of the home's investigation notes revealed two registered staff did not count the hydromorphone narcotics together during the night to day shift change, as per policy.

An interview with RPN #124 revealed that on an identified date when he/she went to the unit to give verbal report to the morning shift, RPN #117 indicated the narcotic count was fine and they did not count the narcotics together. An interview with day shift RPN #117 confirmed that he/she did not do a count of the narcotics together with the night nurse RPN #124, as per the home's policy.

An interview with NM #113 confirmed he/she received five broken and empty ampoules of hydromorphone for destruction on an identified date at 1100h, from RPN #117. He/she confirmed that RPNs #124 and #117 did not do a narcotic count during the night to day shift change. He/she also revealed that RPN #123 did not do a narcotic count with another nurse on the previous day. NM #113 confirmed three identified RPNs received discipline on the importance of doing the narcotic count by two nurses together at shift changes so that any discrepancies can be identified in a timely manner. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the post-fall assessment and the narcotic and controlled drugs administration record policies are complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A review of a CIR from an identified date revealed that resident #010 alleged an identified staff member twisted an identified body part during provision of care.

During an interview with the accused PSW #101, he/she denied the allegation of abuse, however, revealed that on an identified date, he/she transferred resident #010 independently using the an identified lift and the resident fell.

A review of resident #010's written plan of care at the time of the incident, revealed the resident was at risk for falls. The plan of care stated the resident was refusing to be transferred with the an identified lift, as recommended, and directed staff to provide two person extensive assistance for transfers.

Further review of the resident's health care record revealed a few days after the incident, resident #010 complained of pain and was transferred to hospital. He/She was diagnosed with a an identified injury.

A review of the home's transfer policy, revised March 10, 2016, states that residents requiring the use of a mechanical lift and/or ceiling lift will be assisted by two staff at all times to promote both resident and staff safety.

An interview with NM #113 indicated the home's expectation is that two staff members are required to transfer residents when using the an identified lift. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse has occurred, immediately reports the suspicion and the information upon which it was based to the Director.

Record review and interview with resident #030 revealed that he/she reported to staff on the morning of an identified date that PSW #106 had hit him/her on an identified part of the body while he/she was sleeping.

Interviews with registered staff #105 and NM #104 revealed they were both made aware of the allegation on an identified date, and that PSW #106 was immediately removed from the floor pending an investigation. NM #104 confirmed a CIR was not submitted to the MOHLTC.

An interview with the Administrator confirmed the expectation is for any allegation of abuse to be reported to the MOHLTC immediately. [s. 24. (1)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A review of an identified CIR revealed resident #010 sustained a fall while being transferred on an identified date.

A review of resident #010's progress notes revealed a post-fall assessment was not completed for the resident after the incident.

Interviews with RPN #100 and NM #113 confirmed that a post-fall assessment was not completed for resident #010. NM #113 also confirmed that a post-fall assessment should be completed after each fall incident. [s. 49. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A record review of resident #004's most recent resident assessment instrument-minimum

data set (RAI-MDS) assessment,on an identified date, and written plan of care, revealed the resident is incontinent of both bladder and bowel, wears a brief, and is on a scheduled toileting program to help manage his/her incontinence. The resident has been coded on RAI-MDS assessments as incontinent of bladder for an extended period of time.

A review of the home's continence assessment policy, dated May 2016, indicates that registered staff are to complete the continence assessment tool for residents who are incontinent on admission and when there is a change in residents' continence status. Further review of resident #004's clinical record failed to reveal the presence of a cumulative continence assessment tool. At that time, the resident was assessed as being continent of both bowel and bladder.

Interviews with PSW #110 and RN #109 confirmed resident #004 is incontinent of both bladder and bowel, and has not had any recent changes in continence level. RN #109 revealed the home uses an electronic continence management assessment tool to assess residents' continence on admission and with any change in status. RN #109 was unable to locate a continence assessment for resident #004 when his/her continence status changed.

Interviews with registered staff #109 and the associate nurse manager #129 confirmed the home has a cumulative continence assessment tool to assess residents' continence, and there is an expectation all residents receive a continence assessment on admission and with a change in continence status. Resident #004 should have received a continence assessment when his/her continence care needs changed. [s. 51. (2) (a)]

2. A record review of resident #006's most recent RAI-MDS assessment, on an identified date,and written plan of care, revealed the resident is incontinent of both bladder and bowel, wears a brief, and is on a continence program to help manage his/her incontinence. The resident has been coded on RAI-MDS assessments as incontinent of bladder for an extended period. Further review of the resident's clinical record failed to reveal the presence of a cumulative continence assessment tool since the resident's admission.

Interviews with PSW #112 and RPN #111 confirmed resident #006 is incontinent of bladder and bowel, and has not had any recent changes in the continence level. RPN #111 revealed the home assesses continence quarterly using the RAI-MDS assessment, and confirmed that resident #006 has not had a cumulative continence assessment

performed since his/her admission when he/she was continent of both bowel and bladder.

Interviews with RPN #111 and associate NM #129 confirmed that resident #006 should have received a cumulative continence assessment when his/her continence care needs changed. [s. 51. (2) (a)]

Issued on this 15th day of December, 2016

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

Original report signed by the inspector.