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 # / No de registre	Type of Inspection / Genre d'inspection
Dec 15, 2017	2017_652625_0020	026445-17	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

KATHERINE BARCA (625), LAUREN TENHUNEN (196)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): December 4 to 8, 2017.

During the course of the inspection, the inspector(s) spoke with residents, families, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), a Maintenance employee, the Environmental Services Manager (ESM), the Registered Dietitian (RD), the Associate Nurse Manager, the Director of Nursing (DON) and the Administrator.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents and observed staff and resident interactions. The Inspectors also reviewed relevant health care records, incident reports, meeting minutes, policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

On a specific date, Inspector #625 observed that resident #003's bed rails were in one position. The following day, the Inspector observed the resident's right bed rail in the same position and left bed rail in a different position.

A review of resident #003's current care plan, with a focus on bed rail use, identified that the resident used "assist rails". The care plan did not identify the position of the bed rails.

During an interview with Inspector #625, PSW #105 stated that they were not sure which bed rails were raised for resident #003 and in what position they were raised. The PSW stated that the current care plan identified that the resident used "assist rails" and determined that they would be raised vertically [transfer position] on both sides of the resident's bed.

During an interview with Inspector #625, PSW #106 stated that resident #003 used "assist rails" but they were not sure which way the bed rails were raised and thought that the bed rail closest to the door [the right bed rail] was raised vertically [transfer position].

During an interview with Inspector #625, PSW #107 stated that resident #003 used a right bed rail raised vertically [transfer position] and a left bed rail raised horizontally [guard position].

During an interview with Inspector #625, RPN Unit Supervisor #108 stated that, when resident #003 got into bed, the bed rails should be raised vertically [transfer position] and, when the resident got out of bed, the bed rails should be raised horizontally [guard position]. The RPN Unit Supervisor stated that the resident's current care plan was not clear as to whether the bed rails were to be in the transfer or in the guard position.

During an interview with the Associate Nurse Manager, they stated to the Inspector that the term "assist rails" used in resident #003's care plan did not identify whether the bed rails were to be raised in the vertical [transfer] or horizontal [guard] position. The Associate Nurse Manager acknowledged that resident #003's care plan was not clear with respect to the placement of the bed rails.

During an interview with Inspector #625, the Director of Nursing stated that bed rails raised in the vertical [transfer] and guard [horizontal] positions would be considered "assist rails" and that the use of the term "assist rails" in resident #003's care plan did not clearly indicate if the bed rails were to be raised vertically [transfer position] or horizontally [guard position]. [s. 6. (1) (c)]

2. On a specific date, Inspector #625 observed resident #008's right bed rail in one position and the left bed rail in another position. The following day, the Inspector observed both of the resident's bed rails to be in the same position.

A review of resident #008's current care plan, with a focus on bed rail use, identified that the resident used bed rails. The care plan did not identify the position of the bed rails.

During an interview with PSW #110, they stated to Inspector #625 that resident #008 used the bed rails for specific activities, as was identified in Point of Care.

During an interview with Inspector #625, PSW #109 stated that resident #008 used the bed rails for a specific activity.

During an interview with Inspector #625, RPN Unit Supervisor #108 stated that resident #008's care plan did not identify whether the bed rails were to be positioned vertically [transfer position] or horizontally [guard position].

During an interview with Inspector #625, the Associate Nurse Manager stated that the reference in care plans to bed rail use did not identify whether the bed rail was to be

raised in the vertical [transfer] or horizontal [guard] position. The Associate Nurse Manager acknowledged that the lack of specification of bed rail positioning in residents' care plans did not provide clear direction with respect to the placement of the bed rails.

During an interview with Inspector #625, the Director of Nursing stated that bed rails raised in the vertical [transfer] and guard [horizontal] positions would need to be identified as such in residents' care plans in order to provide clear direction as to the positioning of the bed rails and, if they were not, the positioning of the bed rails listed in the care plan would be unclear. [s. 6. (1) (c)]

3. On a specific date, Inspector #625 observed resident #009's bed rails in the same position, with one bed rail mounted to the bed in a different location than the bed rail on the other side. Two days later, at 1210 hours, the Inspector observed one of the resident's bed rails lowered (not in use) and other bed rail rail in a different position from the previous observation. At 1227 hours, one bed rail was observed to be lowered and the other was observed in the position observed two days prior. At 1500 hours, the previously lowered bed rail was observed in the position observed two days prior and the other bed rail was observed in the position observed at 1210 hours.

A review of resident #009's current care plan, with a focus on bed rail use, identified that the resident used "assist rails". The care plan did not identify the position of the bed rails.

During an interview with Inspector #625, PSW #105 stated that resident #009 only used the right bed rail, not the left one. The PSW positioned the lowered (not in use) right bed rail into the horizontal [guard] position and left the left bed rail in the horizontal [guard] position.

During an interview with Inspector #625, PSW #106 stated that resident #009 used bed rails for a particular activity, that the care plan was not clear on whether the bed rails were to be positioned vertically [transfer position] or horizontally [guard position]. The PSW stated they would have to ask the RPN which way the bed rails were to be placed but thought that they may both be positioned horizontally [guard position].

During an interview with Inspector #625, PSW #107 stated that resident #009 used bed rails for a specific activity. The PSW stated that the care plan identified that the resident used the bed rails but did not identify how they were to be positioned. The PSW stated that one bed rail was always in the horizontal position [guard position] as it was mounted at one particular location of the bed and that the the other bed rail was sometimes in the

vertical and sometimes in the horizontal positions. The PSW elaborated that, at particular times, or when specific activities were occurring, one bed rail was kept in the horizontal position, but when staff were on the unit, they placed the other bed rail in the vertical position as they were back and forth in the room to perform specific activities.

During an interview with Inspector #625, RPN Unit Supervisor #108 stated that resident #009 should have both bed rails in the vertical [transfer] position or put into the horizontal [guard] position if the resident needed to support themselves. The RPN Unit Supervisor stated that the care plan did not identify which position the bed rails should be in and confirmed that, at the time of the interview, the right bed rail was in the vertical [transfer] position and the left was in the horizontal [guard] position.

During an interview with Inspector #625, the Associate Nurse Manager stated that the reference to bed rail use in residents' care plans did not identify whether the bed rails were to be raised in the vertical [transfer] or horizontal [guard] position. The Associate Nurse Manager acknowledged that the care plan did not provide clear direction to staff with respect to the position of the bed rails.

During an interview with Inspector #625, the Director of Nursing stated that bed rails raised in the vertical [transfer] and guard [horizontal] positions would need to be identified as such in residents' care plans in order to provide clear direction as to the positioning of the bed rails. The Director of Nursing acknowledged that resident #009's care plan identified the bed rails as "assist rails" only and did not indicate if the bed rails were to be positioned vertically [transfer position] or horizontally [guard position]. [s. 6. (1) (c)]

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

During a staff interview by Inspector #196 and a census review by Inspectors #196 and #625, resident #009 was identified as having an area of altered skin integrity on a particular location on their body.

A review of resident #009's current care plan by Inspector #196, with a focus of altered skin integrity, identified that Health Care Aides/PSWs were to ensure a particular intervention was in place.

On a specific date, during multiple observations between 1145 hours to 1616 hours, Inspector #625 observed resident #009 without the intervention in place.

During an interview with Inspector #625, PSW #106 stated that resident #009 was supposed to have the particular intervention in place as per the Kardex but that the intervention was not being followed at that time.

During an interview with PSW #107, they stated to the Inspector that resident #009's care plan indicated the intervention was required at all times.

During an interview with Inspector #625, RPN Unit Supervisor #108 stated that resident #009 had the intervention in place during the night but they were not sure if the resident had the intervention in place during the day. They confirmed that the resident did not have the intervention in place at the time of the interview and stated that, to benefit the resident, they should have had the intervention in place.

During an interview with Inspector #625, the Director of Nursing stated that, if resident #009's care plan identified that they were to have a particular intervention in place, then intervention should be followed. [s. 6. (7)]

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 that ensures 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, 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, where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedures, strategy or system, that the play, policy, protocol, procedure, strategy or system was complied with.

Ontario Regulation 79/10, s. 114 (2) requires the licensee 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.

A review of the home's pharmacy provider's policy titled "Medication Pass – Policy & Procedure", last reviewed January 17, 2017, identified that staff were to administer medications to residents ensuring that oral medication had been swallowed and that staff were not to leave medications at the bedside unless there was a written physician's order to do so.

On a particular date, at 1600 hours, Inspector #196 observed medication on a paper towel in resident #004's room.

During an interview with Inspector #196, RPN #111 stated that resident #004 was administered the medication observed on the paper towel at 0800 hours daily. The RPN confirmed that the medication was present in the resident's room and that medications were not to be left at the bedside.

A review of resident #004's electronic orders by Inspectors #196 and #625 identified an entry for the medication once daily but did not identify an order for the resident to self-

administer medications.

During an interview with Inspector #625, RN Unit Supervisor #112 stated that medications, including the specific medication observed in resident #004's room, should not be left at the bedside and that staff should ensure that residents take medications administered to them.

During an interview with Inspector #625, the Associate Nurse Manager stated, with respect to the specific medications left at resident #004's bedside, that staff should not have left the medications unattended at the bedside.

During an interview with Inspector #625, the Director of Nursing stated, with respect to the specific medication left at resident #004's bedside, that staff should not have left medications at the bedside for the resident to self-administer, and that the staff should watch residents take medications and not leave them unattended. [s. 8. (1) (b)]

2. A review of the home's pharmacy provider's policy titled "Medication Incident – F-45", revised May 12, 2017, identified that staff were to document a medication incident in the electronic progress notes including an assessment of the resident noting changes in mental status, physical status and behavioural changes, and that staff were to monitor and record the observations in the electronic progress notes.

A review of a Medication Incident Report by Inspector #625, identified that resident #013 had not received medication as ordered on a particular date in the summer of 2017. The report identified that the resident did not receive the medication during a leave of absence and that the home was not notified of the incident until two days after the incident occurred.

A record review of resident #013's electronic progress notes included a note dated the date of the medication incident, which indicated that the resident returned from a leave of absence in satisfactory condition. The progress notes did not contain any entries related to the medication incident that occurred on that date, including an assessment and monitoring of the resident.

During an interview with Inspector #625, the Director of Nursing (DON) confirmed that there were no electronic progress note entries related to the medication incident that occurred on the specific date in the summer of 2017, involving resident #013. The DON also acknowledge that the home's policy titled "Medication Incident – F-45", revised May

12, 2017, indicated that staff were required to document medication incidents, assessments and monitoring in the electronic progress notes. [s. 8. (1) (b)]

3. A review by Inspector #625 of the home’s pharmacy provider’s policy titled "Nursing Section - Disposal of Drugs, Narcotics and Controlled Substances" last reviewed January 17, 2017, identified that all medications were to be stored in a secured, locked location, accessible only to designated staff members. The policy also identified that non-narcotic medication waste was to be rendered unusable and sealed in a destruction container provided by the bio hazardous waste company selected by the pharmacy and that medications were not to be disposed of in sharps containers.

On three consecutive dates, Inspector #625 observed two used medication patches adhered to resident #009’s bed rail. One a particular date, the Inspector was able to identify that one patch was dated a specific date in the spring of 2017.

During an interview with Inspector #625, PSW #105 confirmed that there were two used patches on resident #009’s bed rail and that one was dated the specific date in the spring of 2017.

During an interview with Inspector #625, RN Unit Supervisor #112 stated that the specific medication patches should be removed by Unit Supervisors and the Medication Administration Record should be signed to indicate this. The RN Unit Supervisor stated that staff were to dispose of used medication patches in the sharps containers and they should not be adhered to bed rails.

During an interview with the Associate Nurse Manager, they stated to Inspector #625 that staff should not leave used medication patches on residents’ bed rails but should have disposed of them.

During an interview with Inspector #625, the DON stated that placing the medication patches on bed rails was unsafe handling and disposal of the drug. They stated that the home did not have a policy specific to the removal of the specific type of medication patches but that staff should have removed the patches and then disposed of them in a sharps container. [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 that ensures that, where the Act or 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, that the plan, policy, protocol, procedure, strategy or system, is 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 the residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were 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; and
4. Any other weight change that compromises the resident's health status.

During a record review, by Inspectors #196 and #625, resident #008 was identified as having experienced a significant weight change at a rate in excess of the regulatory limits.

A review of resident #008's electronic health care record by Inspector #625 identified the resident's specific weights on dates during three different months. The record included a notation that the resident experienced a weight change in excess of five per cent of their body weight over one month. The record did not identify that the resident experienced a significant weight change in excess of 7.5 per cent of their body weight over three months.

A review of resident #008's Dietary Assessments for 2017 included:
- a quarterly nutrition summary dated a particular date in the spring of 2017, which identified the resident's current weight as the weight obtained the previous month, the resident's weight had been stable over the past six months and no significant change was to be addressed; and
- a quarterly nutrition summary dated a particular date in the summer of 2017, which identified that the resident appeared to have experienced a significant weight change (which occurred during the month of the quarterly nutrition assessment in the spring of 2017) and was changed to a high nutrition risk related to the weight change.

During an interview with Inspector #625, the Registered Dietitian (RD) acknowledged that they had not completed an assessment for resident #008 based on the significant weight change they experienced in the spring of 2017. They stated that a weight report had been run eight days after the resident's weight was obtained in the particular month in the spring of 2017, but that the resident's significant weight change did not show up in the system. The RD stated that an assessment was not completed for resident #008's significant weight change that occurred in the spring of 2017, until the quarterly nutrition assessment was completed 82 days after the weight was entered into the system. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #4: 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. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Inspector #625 reviewed resident #012's health care record including:
- the current Medication Administration Record (MAR) with an entry for a specific time that identified the resident was to receive a medication at two particular times during the day; and
- a Physician's Order Review dated a particular date in the fall of 2017, that indicated the resident was ordered the medication at two specific times during the day.

A review of the home's pharmacy provider's policy titled "Medication Pass – Policy & Procedure" last reviewed January 17, 2017, identified that the eight rights of medication administration must be observed during mediation administration and that the nurse was responsible to ensure the medication was administered at the right time.

On a particular date, Inspector #625 observed RN Unit Supervisor #112 administer medication to resident #012. The RN Unit Supervisor signed for removal of the medication one hour and 19 minutes after the time listed in the MAR and administered it to the resident a few minutes later.

During an interview with Inspector #625, the RN Unit Supervisor #112 stated that they had a one hour time frame before and after scheduled medication administration times to administer medication. The RN acknowledged that the medication was administered to resident #012 outside of that time frame.

During interviews with the Associate Nurse Manager, they stated to Inspector #625 that the staff had a one hour time frame before and after scheduled medication times to administer the medication; an order that read "at [a specific event]" meant the medication was to be administered at a specific time; resident #012 should have been administered the medication before the resident went to the event; and the administration of the medication to the resident at the time it was given was late.

During an interview with the DON, they stated to Inspector #625 that staff should not administer medications outside of the one hour time frame before and after scheduled medication administration times, and that resident #012 should have received the medication scheduled for the specific time before they went to a specific event. [s. 131. (2)]

Issued on this 16th day of January, 2018

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

Original report signed by the inspector.