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**

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Nov 17, 2014 | 2014_261522_0030 | T-000013-14 | Resident Quality Inspection |

**Licensee/Titulaire de permis**

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

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

CEDARVALE LODGE
121 Morton Avenue, Keswick, ON, L4P-2M5

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

JULIE LAMPMAN (522), INA REYNOLDS (524), NANCY JOHNSON (538)

**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): October 27, 28, 29, 30, November 3, 4, 5, 6, 2014**

**During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Clinical Services, Director of Wellness,Director of Resident Programs and Admissions, Director of Dietary Services, Maintenance Manager, Food Services Manager, Staffing Coordinator, RAI Coordinator, four Registered Nurses, three Registered Practical Nurses, seven Personal Support Workers, a Dietary Aide, a Laundry Aide, a Housekeeper, a Dietitian, four Family Members and forty Residents**

**During the course of the inspection, the inspector(s) toured all resident home areas, the medication room, observed dining service, medication pass, provision of resident care,**
**recreational activities, staff/resident interactions, infection prevention and control practices, reviewed resident clinical records, posting of required information and relevant policies and procedures, as well as minutes of meetings pertaining to the inspection.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Laundry**
**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Residents' Council**
**Safe and Secure Home**
**Skin and Wound Care**
**Sufficient Staffing**
**Training and Orientation**

**Findings of Non-Compliance were found during this inspection.**

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

**WN #1: The Licensee has failed to comply with 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).**

**Findings/Faits saillants :**

1. 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.

Review of a specified resident's Annual MDS Assessment revealed the resident is totally incontinent.

Review of the resident's clinical record care plan revealed staff were to "evaluate the resident's bladder control pattern" as an incontinence intervention. Further review of the resident's clinical record revealed no documented evidence of an evaluation being completed.

Interview with Director of Wellness (DOW) revealed that when a resident is totally incontinent, staff would not evaluate the resident's bladder control pattern.

The DOW confirmed that the care plan does not provide clear direction to the staff and others who provide direct care to the residents. [s. 6. (1) (c)]

2. a) A record review of the most recent quarterly review Minimum Data Set (MDS) Assessment for a specified resident under the toilet use section revealed the resident requires "Extensive Assistance – one person physical assist". However, the plan of care for this resident and the Kardex posted in the resident's closet identifies the following interventions related to toileting: "staff to provide supervision/cueing/encouragement without physical assistance".

Interview with the Personal Support Worker confirmed the resident's toileting needs had changed and the resident requires extensive assistance with toileting.

b) A record review of the most recent quarterly review Minimum Data Set (MDS) Assessment for a specified resident under the toilet use section revealed the resident requires "Limited Assistance – Set up help only". However, the plan of care for this Resident identifies the following intervention related to toilet use: "Toileting: No assistance required".

This was confirmed by the RAI Coordinator who stated that the resident's toileting needs had changed as documented in the flow sheets completed by the Personal Support Workers. [s. 6. (1) (c)]

3. Review of a specified resident's Care Plan revealed the following interventions for toileting: "two staff to provide weight bearing support to transfer on/off the toilet (sarah

lift when necessary."
However, further review revealed the following interventions regarding incontinence:"One staff for cueing to go to the bathroom with assistance from staff."

Interview with the Personal Support Worker revealed that the resident does require a two person transfer for toileting.

Interview with the Director of Wellness confirmed that the plan of care provides conflicting information related to the resident's toileting needs.

The Director of Wellness confirmed it is the home's expectation that resident care interventions for toileting is reflective of the resident's current status and the written plan of care provide clear direction to staff and others who provide toileting care for the resident. [s. 6. (1) (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 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.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

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

**s. 15. (2) Every licensee of a long-term care home shall ensure that,**
**(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
**(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

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**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home is maintained in a good state of repair.

Observation of multiple resident rooms and common home areas revealed numerous paint chips on walls and doors, gouges on doors and door frames and corrosion on bathroom mirrors.

Review of the home's Painting Program policy # XVII-D-200.00 page 1 of 1 dated September 2005 and last revised May 2013 revealed:

"An audit will be conducted every 4 months throughout the home, including resident rooms and common areas, to determine painting priorities. Painting includes touch ups and corner guard replacement. A painting schedule will be developed based on the priorities identified."

Review of the home's Maintenance Program policy XVII-D-5.00 page 1 of 1 dated November 2005, last revised December 2012 revealed:

"The home shall establish and implement a maintenance program to ensure both interior and exterior areas and operational systems are in good repair and maintained. The Director of Environmental Services/Maintenance Manager or designate will carry out preventative maintenance on a daily, weekly, monthly, quarterly, semi-annual and annual basis as per task schedule."

A review of the task schedule revealed resident room inspections are to be completed two times a year.
The Director of Maintenance completed an audit of resident home areas in June 2014. It was the only audit completed this year and no formal schedule for completion has been completed at the time of the RQI.

Interview with the Director of Maintenance confirmed that the process is not being followed and was unable to provide a painting schedule based on priority for the home.

Interview with the Executive Director confirmed that the home is not in a good state of repair and that it is an expectation of the home that it is maintained. [s. 15. (2) (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 is maintained in a good state of repair, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services**

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

**s. 31. (3) The staffing plan must,**
**(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).**
**(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).**
**(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).**
**(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).**
**(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).**

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**Findings/Faits saillants :**

1. The licensee has failed to ensure that the staffing plan is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Interviews with three residents revealed that they had concerns with the timeliness of staff when assistance was requested and having to wait long periods of time for care.

Record review revealed there is a staffing plan in place, but there is no documented evidence that this plan is evaluated and updated at least annually.

Interview with the Executive Director and the Director of Clinical Services on November 5, 2014 confirmed that the staffing plan is not updated annually with a written evaluation. [s. 31. (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 the staffing plan is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

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

**s. 50. (2) Every licensee of a long-term care home shall ensure that,**
**(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
**(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,**
**(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,**
**(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and**
**(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).**

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**Findings/Faits saillants :**

1. The licensee has failed to ensure the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Observation of a specified resident revealed the resident had altered skin integrity.

Interview with the Registered Practical Nurse (RPN) and the Personal Support Worker (PSW) revealed the altered skin integrity was a chronic issue for the resident.

Interview with the Registered Nurse confirmed the altered skin integrity has been chronic since the resident's admission.

Review of the home's Skin and Wound Care Management Protocol Policy VII-G-20.10 revealed:

"With a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds Registered Staff will:
a. Conduct a skin assessment
b. Provide immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection."

Review of the resident’s Admission Head to Toe Assessment revealed the resident had altered skin integrity upon admission.

Further record review revealed the absence of a skin wound care assessment related to the altered skin integrity. Review of quarterly Head to Toe Assessments revealed the absence of documentation related to the altered skin integrity.

The Registered Nurse confirmed the absence of a documented skin assessment and confirmed the expectation that the resident have a skin assessment related to the altered skin integrity.

Interview with the Director of Clinical Services confirmed that skin assessments were not completed for the wound on the resident’s nose. [s. 50. (2) (b) (i)]

***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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.***

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**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).**

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**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, is conducted using a clinically appropriate assessment instrument.

A specified resident was noted to be continent of bladder and bowel according to the Admission Minimum Data Set (MDS) Assessment on Point Click Care. A clinical record review of the most recent quarterly review assessment revealed the resident had a decline in bladder and bowel function and is totally incontinent of urine and bowel. There is no documented evidence of a continence assessment for this resident.

The Director of Wellness confirmed that a continence assessment was not completed for this resident to identify causal factors, patterns, type of incontinence and potential

to restore function. [s. 51. (2) (a)]

2. Review of a specified resident's interdisciplinary care conference notes revealed the resident's incontinence level had deteriorated and was incontinent of urine and occasionally incontinent of bowel.

Review of the resident's clinical record revealed the absence of a documented incontinence assessment. This was confirmed by the Registered Nurse.

Interview with the Registered Nurse revealed that use of a clinical assessment tool for incontinence had been initiated in July 2014 and not all residents have had an assessment as residents would be assessed as part of their annual interdisciplinary care conference.

Interview with the Director of Clinical Services confirmed that use of the incontinence assessment tool was new and not all resident's had been assessed. [s. 51. (2) (a)]

3. Review of the hard copy clinical record for a specified resident revealed a paper copy of a Continence Program - Admission and Annual Continence Assessment that had numerous omissions.

Interview with Director of Wellness (DOW) covering for the Director of Clinical Services confirmed that the assessment was incomplete. Further discussion revealed that the electronic clinically appropriate assessment instrument that is specifically designed for assessment of incontinence was available and was not used by the registered staff for the assessment.

The Director of Wellness confirmed that the home did not complete the incontinence assessment using the clinically appropriate assessment tool. [s. 51. (2) (a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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, is conducted using a clinically appropriate assessment instrument, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service**

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

**s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,**
**(a) procedures are developed and implemented to ensure that,**
**(i) residents' linens are changed at least once a week and more often as needed,**
**(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,**
**(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and**
**(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).**

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**Findings/Faits saillants :**

1. The licensee has failed to ensure that as part of the organized program of laundry services the procedure developed was implemented to report and locate residents' lost clothing and personal items.

A review of the home's Missing Resident Laundry policy #XII-K-20.50 dated May 2002 and last revised April 11, 2011 revealed:
"All missing personal clothing that is reported will be recorded on the Missing Laundry form and every effort will be made to locate them.
The PSW will:

1. Ensure that the Missing Laundry FORM (XII-K-11.50 (a) is made readily available to families in each home area.
2. Assist the resident/family in completion of this form when an item is reported missing.
3. Conduct a search of the resident room and area for lost clothing.
4. Report the lost item by forwarding the Missing Laundry Form to the laundry staff if the item is not found in the home area.

The Director of Support Services will:

1. Follow up on a monthly basis on all lost items that are not resolved.
2. Organize a time for families to review unlabeled clothing items on a regular basis."

Interviews with eight residents revealed that they were missing various items of clothing from the laundry.

Interview with Laundry Aide (LA) revealed the LA was unfamiliar with the home's process for missing laundry.

Interview with the Director of Programs and Admissions revealed that the process for missing laundry is not completed as per policy.

Interview with the Maintenance Manager and the Executive Director confirmed that the home's policy and procedure for missing laundry has not been followed.

The Executive Director confirmed the expectation that the home's procedure to report and locate residents' lost clothing and personal items is implemented. [s. 89. (1) (a) (iv)]

***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 as part of the organized program of laundry services that the procedure developed is implemented to report and locate residents' lost clothing and personal items, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 216. Training and orientation program**

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

**s. 216. (2) The licensee shall ensure that, at least annually, the program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 216 (2).**

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**Findings/Faits saillants :**

1. The licensee has failed to ensure that the training and orientation program is evaluated and updated at least annually in accordance with evidence based practices and, if there are none, in accordance with prevailing practices.

Interview with the Director of Wellness who is the lead for training and orientation revealed the home does not complete a written evaluation and update their training and orientation program annually.

Interview with the Executive Director confirmed the home does not complete an annual evaluation of the home's training and orientation program and that the home was unaware of the expectation to do an annual evaluation and update of the program. [s. 216. (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 the training and orientation program is evaluated and updated at least annually in accordance with evidence based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.***

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**WN #8: 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. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:**
**1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).**
**2. Skin and wound care. O. Reg. 79/10, s. 221 (1).**
**3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).**
**4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).**
**5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).**
**6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).**

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**Findings/Faits saillants :**

1. The licensee has failed to ensure that all staff who provide direct care to residents receive additional training in the following areas:
1. Falls prevention and management;
2. Skin and wound care;
3. Continence care and bowel management;
4. Pain management.

Review of the home's Education Summary for 2014 revealed direct care staff had not had additional training in the above areas as of the date of the RQI.

Review of the home's Education Summary for 2013 revealed:
21% of direct care staff received training in Continence
21% of direct care staff received training in Falls Prevention
21% of direct care staff received training in Skin and Wound Education
38% of direct care staff received training on Pain.

Interview with the Director of Wellness and Director of Clinical Services confirmed that home has not provided training to all direct care staff in the above areas.

Interview with the Administrator revealed the home was unaware of the expectation that all direct care staff receive education in Falls Prevention, Continence, Skin and Wound and Pain. [s. 221. (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 all staff who provide direct care to residents receive additional training in Falls Prevention, Continence, Skin and Wound and Pain, to be implemented voluntarily.***

**Issued on this 24th day of November, 2014**

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