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 sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 27, 2016	2016_440210_0006	009320-16	Critical Incident System

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

SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 6, 7 and 8, 2016

During the course of the inspection, the inspector(s) spoke with personal support workers (PSW), registered nurses(RN), physiotherapy assistant (PTA), physiotherapist (PT), director of care (DOC), substitute decision maker (SDM), physician, reviewed the clinical record and observed provisions of care.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Personal Support Services

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Interview with PSW #102 revealed that when he/she was assisting resident #001 with morning care, he/she was using a mechanical lift, since an identified date in 2016. The staff indicated that the resident had more strength in the evening and was able to be transferred with pivot transfer and assistance of one or two people. PSW #102 revealed that he/she assisted the PTA with resident 001's walking exercise on two identified dates in 2016, when the PTA assessed that the resident did not have good balance and required two person assistance with the walking exercise.

Observation of resident #001's room on an identified date, revealed two transfer logos on the wall. One logo indicated a requirement for one person pivot transfer and another one for a mechanical lift, as needed (PRN).

A review of a Critical Incident Report (CIR), revealed that on an identified date, resident #001 had an incident in his/her bathroom when he/she was assisted by an identified staff with morning care.

Interview with PSW #107 revealed that in the morning when the incident happened, he/she chose to transfer resident #001 with pivot transfer. PSW #107 noted the two logos on the wall, one for pivot transfer and another one for a mechanical lift as required (PRN). Further, the staff indicated when the resident was assisted with transferring from the wheelchair to the toilet, the resident held the rail by the sink in order for the PSW to perform the morning care. Unexpectedly, the resident lost his/her balance and struck one part of the body on the sink counter. The resident sustained an injury. A review of the progress notes revealed on an identified date after the incident, the resident presented with weakness on one side of the body and was transported to the hospital.

Interview with PT revealed that a referral had been received for a post fall assessment of resident #001 and had attempted to assess the resident after the incident. The PT indicated that the resident did not have good balance while standing and walking in the physiotherapy program. The resident was assessed to require a two person assist while walking. The PT revealed it was not safe for the resident to stand and hold the sink rail without support while being provided morning care. The PT indicated that his/her assessment was communicated with PTA but not with other staff who provides direct care to the resident.

A review of the PT assessment for balance, approximately three weeks before the incident, indicated the resident balance while standing was 2, which meant the resident required partial physical support during the test. A review of the physiotherapy flow sheets revealed that two weeks before the incident, the resident required two-person assistance with the walking program.

Interview with the PTA, PSW #102, PSW #107, registered staff #103 and the DOC indicated when resident #001's health status changed and required two-person assistance with walking and when staff #102, used the mechanical lift to transfer resident #001 during morning care, it should be communicated to the other PSWs and the

registered staff in order for the plan of care to be updated. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the resident, the SDM,if any, and the designate of the resident/SDM has been provided the opportunity to participate fully in the development and implementation of the plan of care.

Interview with the PTA revealed that resident #001 participated in the walking exercise program as part of the physiotherapy program for three months in 2016. During the walking exercise program the resident was walking with assistance of the walker and for everyday mobility the resident was using a wheelchair. Further, the PTA indicated that the resident required one-person assistance with walking until two weeks before the incident, when the resident was assessed to be weak and unstable and required two-person assistance with walking. A review of the physiotherapy flow sheets indicated the resident walked several times a week before the incident, with assistance of two people.

Interview with the family member, who was the substitute decision maker (SDM), indicated no awareness that the resident participated in the walking program. The SDM indicated that his/her impression was that the resident was not able to walk or stand. He/she was not aware that the walker in the resident's room was utilized for the walking program by resident #001.

Interview with DOC indicated that the SDM should be informed about the resident's treatment interventions. A review of resident #001's clinical record including the progress notes and interviews with PT, PTA and DOC confirmed that the resident's SDM was not informed about the resident's participation in the physiotherapy exercise program. [s. 6. (5)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective.

A review of the most recent resident 001's written plan of care, revealed the resident required supervision/cueing/encouragement physical assistance limited to transfer for toileting, supervision and assistance for dressing, reminders/verbal cues and minimal assistance with hygiene and grooming, some physical assistance with bathing, and no assistance with performing the mouth care.

Interview with PSW #107 revealed the resident required extensive assistance from staff

with toileting, dressing, hygiene, grooming, bathing and mouth care in the last three months. A review of the PSW flow sheets indicated that during an identified period of three months before the incident, the resident required extensive assistance in 90 per cent of the cases for transfer, toileting, dressing, hygiene, grooming, bathing and mouth care.

Review of resident #001's written plan of care and interviews with PSW #107, registered staff #103 and the DOC confirmed the written plan was care was not reviewed and revised when the resident health status changed and required more assistance by staff for the activities of daily living. [s. 6. (10) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, the designate of the resident/SDM has been provided the opportunity to participate fully in the development and implementation of the plan of care, the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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 plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

A review of the home's "Falls Prevention" policy, dated January 2015, revealed that the registered staff will initiate a head injury routine (HIR) if a post fall assessment indicates that a head injury is suspected. Registered staff to monitor HIR as per schedule on the form post fall for signs of neurological changes, i.e. facial droop, behavioral changes, weakness on one side, etc. A review of the HIR form revealed that the head injury routine is done every 15 minutes for an hour, every 30 minutes for two hours, every hour for three hours, every two hours for eight hours, and every four hours for 12 hours or until directed by the physician to cease monitoring.

A review of the CIR, revealed that on an identified date, resident #001 sustained an injury during the morning care. The resident lost his/her balance and struck one part of the body on the sink counter. Registered staff #103 initiated a head injury routine (HIR) assessment and documented on the HIR form three times during the day shift. The evening registered staff documented one time during the evening shift.

Interviews with registered staff #103 and DOC indicated that when there is indication a HIR form should be completed for a period of 24 hours and confirmed that after the incident, the HIR form for resident #001 was not completed. [s. 8. (1) (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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's physical functioning and the type and level of assistance required for activities of daily living (ADL) including mobility and locomotion.

A review of resident #001's written plan of care failed to reveal a section with the resident's physical functioning and the type and level of assistance required for ADL including mobility and locomotion. The written plan of care contains a section for mobility as part of the physiotherapy program but not for ADL.

Interview with PTA and PT revealed that they assess the resident's physical functioning and document it in the written plan of care as part of the physiotherapy exercise program but not for ADL.

Interview with PSW staff #102, #103, #106, and #107 indicated when resident #001 was admitted in the home, he/she was able to walk independently with assistance of a walker. The staff was aware that the resident was presently using a wheelchair for locomotion not a walker. Further, they were aware that the resident participated in the walking physiotherapy program.

Interview with registered staff #103 revealed that he/she was not able to document the resident's physical functioning and the type and level of assistance required for walking and locomotion in the written plan of care because there was no separate section for the nursing department to document. Interview with DOC indicated the ADL walking and locomotion care plan should be documented in the same section where the PT documents the walking exercise program.

Review of the written plan of care and interviews with the DOC and registered staff #103 confirmed that the written plan of care was not based on an interdisciplinary assessment of the resident's physical functioning and the type and level of assistance required for activities of daily living including walking and locomotion. [s. 26. (3) 7.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Interview with identified staff PSW #102, #106 and #107 and registered staff RN #107 indicated resident #001 complained of chronic pain on a specified part of the body and PSWs applied a cream locally on the affected area, two times a day, for a period of three months. Registered staff #107 indicated the resident was prescribed the local treatment for pain on an identified date.

A review of the resident #001's electronic treatment record (eTAR) for a period of one month, when the cream was applied, revealed no signature by registered staff that the cream was applied two times a day. During the following period of two months there was only one signature for each month that the cream was applied.

Interview with registered nursing staff #107 and DOC confirmed that the local pain treatment for resident #001 was not documented as prescribed by the physician over the three month period. [s. 30. (2)]

Issued on this 28th day of April, 2016

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

Original report signed by the inspector.