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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 19, 2013	2013_168202_0046	T-444-13	Complaint

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

VALERIE JOHNSTON (202)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 04, 05, 06, 2013

During the course of the inspection, the inspector(s) spoke with General Manager, Director of Clinical Services, Director of Dietary Services, Cook, Registered Nursing Staff, Personal Support Workers, Residents

During the course of the inspection, the inspector(s) observed the provision of care to residents, reviewed clinical records, observed lunch meal services, reviewed the home's policies related to food production temperatures, reviewed food temperature records, reviewed resident council and food committee minutes

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Dining Observation

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs is fully respected and promoted. [s.3(1)4]

During the course of this inspection on September 04, 05, 06, 2013, random residents were interviewed throughout the home. Residents indicated that there are long wait times for staff assistance and call bells are not always within reach. Residents indicated that once the call bell is activated, the average wait time for staff assistance can be anywhere from to 20-30 minutes.

Resident #002's plan of care identifies this resident as requiring staff assistance for toileting and is on a toileting program. Resident #002 indicated in an interview that he/she requires toileting assistance from staff and will use the call bell to request staff assistance. Resident #002 indicated however that he/she has to wait for long periods of time for staff to come and the wait is so long that he/she will often have accidents. [s. 3. (1) 4.]

2. Resident #006's plan of care identifies this resident requiring two staff assistance for toileting and is on a toileting program to be toileted after meals and before bed. Resident #006 indicated in an interview that he/she requires toileting assistance by staff and will use the call bell to request assistance. Resident #006 indicated however that he/she has to wait for long periods of time for staff assistance primarily after lunch and dinner and will often have accidents waiting. [s. 3. (1) 4.]

3. Resident #009's plan of care identifies this resident as requiring two staff assistance with the use of a mechanical lift, is on a toileting program, is to be toileted before programs, before bed, a toileting aide and call bell to be within reach at all times. An interview with resident #009 revealed that when he/she requires staff assistance he/she can wait up to 30 minutes for staff to arrive resulting in accidents. Resident #009 indicated that there are times when he/she is unable to access the call bell because it has fallen between his/her bed and the wall as staff do not always ensure placement before leaving his/her room. Resident #009 indicated that his/her toileting aide is always kept in the washroom making it difficult for him/her to reach while he/she is in his/her wheelchair. On September 05, and 06, 2013 resident #009's toileting aide was observed to be placed in his/her washroom and not within his/her reach. [s. 3. (1) 4.]

4. Resident #010's plan of care identifies this resident as requiring rest periods at 1000 hours and 1300 hours and is a two person mechanical lift transfer. On September 04, 2013 at 15:30 hours, resident #010 was observed to be in his/her room sitting on his/her wheelchair calling out requesting to go to bed, the call bell was located on the side of the bed opposite from where resident #010 was positioned. The inspector activated the call bell for resident #010 at 15:30 hours, which was answered by a Personal Support Worker (PSW) at 15:38 hours, resident was then transferred to the main lobby in his/her wheelchair.

A review of the resident council meeting minutes for January 2013-August 2013, revealed that on July 09, 2013 residents indicated concern that call bells are always out of their reach. [s. 3. (1) 4.]

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 resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs is fully respected and promoted, to be implemented voluntarily.

WN #2: 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. (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 failed to ensure that the care set out in the written plan of care is provided to the resident as specified in the plan. [s.6.(7)]

Resident #001's written plan of care identifies this resident as moderate risk for falls and requires a high low bed which is to be in the lowest position while he/she is in bed. Staff interviews revealed that resident #001 is a high risk for falls and will attempt to transfer him/herself from bed to his/her wheelchair and back to bed. Staff interviews indicated that resident #001 is to have his/her bed in the lowest position at all times when he/her is in bed. During the course of this inspection on September 04 and 05, 2013 resident #001 was observed to be in bed sleeping with the bed raised in a high position. [s. 6. (7)]

2. A review of resident #009's written plan of care revealed that he/she requires two staff assistance with the use of a mechanical lift, is on a toileting program, is to be toileted before programs, before bed, and a toileting aide is always to be within reach. Resident #009 indicated in an interview that his/her toileting aide is kept in the washroom and is difficult for him/her to reach, and at times will drop it on the floor. On September 05, and 06, 2013 resident #009's toileting aide was observed to be placed in his/her washroom and not within his reach. Staff interviews indicated that all toileting aides for residents are kept in the washroom, with the exception at night when toileting aides are kept at the resident's bed side. The Director of Care confirmed in an interview that all toileting aides are to be kept in the resident's washrooms unless they are in bed and at which time they would be attached to the side rail of the bed. [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 to ensure that the care set out in the written plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that food and fluids are served at a temperature that is both safe and palatable to the residents. [s.73.(1)6]

During the course of this inspection on September 04, 05, 06, 2013 random residents were interviewed throughout the home which revealed that the food at times is served cold. The home's Food Temperatures-Production policy dated September 2010, directs dietary staff to take hot food temperatures prior to placing hot food in the hot holding cabinet and recording the temperature in the Food Temperatures-Point of Service form. A review of the Food Temperatures-Point of service form for August 2013-September 2013 revealed no recorded temperatures of foods served for the following dates:
August 04, 05, 10, 11, 16, 22, 24, 25, 30, 31, 2013 and September 01, 02, 03, 2013 for breakfast.
August 02, 04, 11, 12, 16, 18, 23, 26, 30, 31, 2013 and September 01, 02, 2013 for lunch.
August 09, 11, 12, 31, 2013 for dinner. An interview with the Director of Dietary Services (DDS) indicated that the home uses the Food Temperatures-Point of service form to verify the temperatures of foods served. The DDS confirmed that the temperatures had not been taken on the above documented dates and was unable to verify the actual temperatures of foods served. [s. 73. (1) 6.]

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Issued on this 19th day of September, 2013

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