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

Division de la responsabilisation et de la performance du système de santé
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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
Feb 26, 2016	2016_252513_0003	033028-15/020417-15	Complaint

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

JUDITH HART (513)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 8, 9, 10, 11, and 12, 2016.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), Registered staff, Physiotherapist, Physiotherapist Assistant, Director of Nursing and Administrator.

During the course of the inspection, the inspector observed staff to resident care and interaction, reviewed resident health records, and policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 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 a resident has fallen and has been assessed and, if required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Progress notes,on specified dates, identified the resident as a high risk for falls.

Progress notes, on a specified date and time, indicated resident #002 fell in a location and sustained an injury.

Interview on a specified date with registered staff #112, reported that on a specific night when resident #002 fell, the resident removed the call and bed alarms and indicated that following the fall, a post-falls assessment had been completed. The post-falls assessment could not be found in the medical record by registered staff #101.

On a specified date, a further review of the resident's clinical record did not identify a post-fall assessment had been completed for the fall identified. An interview with the Director of Nursing (DON) confirmed it was an expectation that a clinically appropriate post-falls assessment be completed after a resident fall. The DON confirmed for the fall identified, a post-fall assessment was not completed, using a clinically appropriate assessment instrument specifically designed for falls. [s. 49. (2)]

Issued on this 3rd day of March, 2016

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

Original report signed by the inspector.