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 prévue le Loi de 2007 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

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Aug 28, 2018;	2018_462600_0010 (A1)	008108-17, 009211-17, 014926-17, 020155-17, 021889-17, 023209-17, 024514-17, 005561-18	Critical Incident System

Licensee/Titulaire de permis

Cedarvale Terrace LTC Inc. as general partner of Cedarvale Terrace LTC Limited Partnership
c/o All Seniors Care Living Centres 175 Bloor Street East, Suite 601 TORONTO ON M4W 3R8

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

Amended by GORDANA KRSTEVSKA (600) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Extension of the compliance date to meet the home request for extension.

Issued on this 28 day of August 2018 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Amended by GORDANA KRSTEVSKA (600) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): June 11, 12, 13, 14, 15,18, 19, 20, 21, 22, 25, 26, 27, and 28, 2018.

During this inspection the following critical incident system (CIS) reports were inspected:

#008108-17, #023209-17, and #024514-17, related resident to resident physical abuse;

#009211-17, and #021889-17, related to fall resulting in injury;

#014926-17, #020155-17, and #005561-18, related to resident to resident sexual abuse;

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Nurse Manager, Associate Nurse Manager (ANM), Behaviour Support Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Nursing Assistant, Staff development coordinator, Manager of Clinical Informatics (MCI), Nursing Restorative Therapist, Social Services Coordinator, Housekeeping staff and residents.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

During the course of the original inspection, Non-Compliances were issued.

5 WN(s)
2 VPC(s)
2 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #021 was protected from abuse by anyone.

For the purposes of the definition of sexual abuse O. Reg. 79/10, subsection 2 (1) defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date, about an incident of abuse toward resident #021 on a specified date. The incident occurred in the resident's room which is shared room for two residents. On a specified date, PSW #128 found resident #021 lying in a bed with removed bed cover and garment . Resident #022 was standing by the bed touching resident #021 inappropriately.

A review of Minimum Data Set (MDS) assessment record on an identified date, indicated resident #021 was mostly bed-fast, with cognitive impairment and increased Cognitive Performance Scale (CPS) score. Resident #022 was ambulatory, with modified independence for decision-making and low CPS score.

During interviews PSW #122 and RN #113 stated they had not seen resident #022 exhibiting identified behaviours towards residents. Further the interviewees indicated they were surprised by resident #022's action as the resident had never exhibited identified behaviours before, and resident #021 would not be able to give consent. However the RN stated that in this case, resident #021 had been abused by resident #022.

An interview with PSW #128 confirmed that on a specified date, they found

resident #022 standing over resident #021. The PSW confirmed that resident #021 was inappropriately touched by resident #022 indicating abuse.

Resident #021 was discharged from the home after this incident. An interview with resident #022 indicated no recollection of the incident.

A review of the home's clinical census record indicated that the home had not implemented the recommendation made by external resource teams of moving rooms/ roommate if current roommate is vulnerable and cannot speak for themselves.

An interview with Nurse Manager #106 and the Director of Care confirmed resident #022 did not have a history to indicate abusive behaviour, however on a specified date, resident #022 performed non-consensual inappropriate touching towards resident #021. [s. 19. (1)]

2. The licensee has failed to ensure that resident #024 was protected from abuse by anyone in the home.

For the purposes of the definition of physical abuse O. Reg. 79/10, subsection 2 (1) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

A CIS report was submitted to the MOHLTC on an identified date for an incident of resident to resident physical abuse that happened on a specified date.

A review of the CIS incident indicated involvement of residents #024, #025, and #026. On an identified date in 2017, in the TV lounge, resident #024 was taking away the assistive device of resident #026. Resident #026 was screaming and trying to get the device back, as resident #024 was pulling the device aside. Resident #024 then lifted up their hand as they were trying to hit resident #026. When resident #025 heard resident #026 screaming and saw resident #024's hand up, they went to resident #024, took their hand, grabbed them and held them in the corner. Residents were separated immediately. Residents #025 and #026 were stable, and placed on monitoring check. According to the staff interview with resident #025, resident #026 was not hit, however resident #024 sustained altered skin integrity. Resident #024 was transferred to outside resources and returned on an identified date, with an identified medical diagnosis. The team continued to follow up with the residents.

An interview with resident #025 indicated that they were irritated by the screaming voice of resident #026 and the loud voice of resident #024 who was yelling at resident #026. The resident confirmed that they approached resident #024, grabbed them on their shirt, "threw" them in the corner as resident #024 would not stop talking and disturbing resident #026.

A review of resident #024's plan of care indicated the staff had identified resident #024 exhibited responsive behaviour and although the triggers were unpredictable, the plan of care was set for staff to address the behaviour at any time. The resident was referred to outside resources for further assessments and treatments. At the time of inspection the resident was discharged from the home as they were still outside the home.

An interview with PSW #123, RPN #108 and the Staff Development Coordinator (SDC) indicated that resident #024's behaviour had been managed most of the time. Resident #025 was known to staff to prefer a certain environment. The resident was identified to have a certain resident that they would spend time. The yelling of resident #024 and the screaming of resident #026 triggered resident #025's responsive behaviour.

A interview with Staff development coordinator confirmed resident #024 was physically abused by resident #025.

3. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A CIS was submitted to the MOHLTC on an identified date about an incident that happened on a specified date regarding an inappropriate behaviour of resident #027 towards resident #028. Review of the LTCH Inquiry and Intake information record indicated the home had submitted a CIS on another specified date for the same residents concerning the same issue.

A review of the CIS indicated that on the identified date resident #028 was found in resident #027's room beside the bed. Resident #027 was sitting on the floor in front of the bed, with no undergarment. Resident #028 was standing in front of resident #027. Resident #027 was seen inappropriately touching resident #028 with their hand.

A review of the previous CIS indicated seven days earlier, resident #027 was found in their bed standing over resident #028. In both incidents the residents were separated, taken to their rooms and placed on safety checks.

A review of resident #028's health record indicated the resident had cognitive impairment and increased CPS score. The staff was aware of the resident's identified responsive behaviour and safety check every 15 minutes was set in the plan of care for staff to monitor the resident and to keep the resident in a safe environment.

A review of resident #027's health record indicated the resident had a cognitive impairment with identified responsive behaviour, and set up interventions for staff to follow. However the resident had not exhibited verbal or physical behaviour towards resident #028. They treated resident #028 as familiar person and they kept visiting resident #028's room, until staff confronted them to stop.

An interview with PSWs #150 and #151 indicated they check the resident according to the schedule but resident #028 kept exhibiting the identified behaviour. The staff also indicated that resident #027 would enter in and out of resident #028's room until the staff told them that was not appropriate and they stopped visiting resident #028.

An interview with ANM #106 stated resident #028 had cognitive impairment and was not able to give consent. The ANM confirmed in this case, the home had not protected resident #028 from abuse. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies that had been developed were implemented to respond to the resident demonstrating responsive behaviours, where possible.

A CIS report was submitted to the MOHLTC on an identified date about an incident on a specified date for abuse toward resident #021. The incident occurred in a common are between two residents. On the identified date PSW #128 found resident #021 lying in bed with removed bed cover and undergarment. Resident #022 was standing by the bed inappropriately touching resident #021.

A review of resident #022's health record indicated resident #022 had exhibited inappropriate responsive behaviour on few occasions in 2017.

Resident #022 was referred to an external team for assessment the same day and the resident was assessed. One of the recommendations from the team was again for the home to consider a room transfer moving one of the residents.

A review of the home's clinical census record indicated that the home had not implemented the recommendation made one month earlier by the external team, of moving rooms/ roommate if current roommate is vulnerable and cannot speak for themselves.

An interview with Staff development coordinator #147 indicated all interventions recommended had been followed by the staff the best possible way. However the transfer of residents from one room to another was up to the management level to proceed with and it was not easy considering other residents' demands.

An interview with DOC indicated the home was aware of the recommendations and the interdisciplinary team had discussed together to make sure they follow up with the recommendation, but the DOC was not able to explain why the transfer of the residents as a plan of care was not provided when recommended.

The DOC confirmed that the strategy for transferring resident #022 as recommended was not implemented by the home. [s. 53. (4) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and consistent with and complemented each other.

A CIS report on an identified date received through the Critical Incident System, stated that resident #012 had an incident on a specified date and sustained an injury on an identified body part.

A review of the progress notes for resident #012 and interview with RPN #131 indicated that resident #012 experienced an incident on a specified date. Upon assessment, resident #012 complained of discomfort and the body part was observed to have changed. Home physician was notified and a diagnostic procedure was ordered. An entry in the progress notes four days later, stated that a staff member received a message from the diagnostic service provider that resident #012 had sustained an injury of the body part. Further review of the progress notes for resident #012 indicated that the result of the above mentioned result was communicated to the doctor six days later, and the doctor ordered to send the resident for further treatment. Resident #012 returned to the home later with an applied treatment on the identified body part.

In interviews, RPNs #131 and #146 stated that actions were required when staff received the results. If there was no injury, staff would leave a note in the doctor's communication book to remind the doctor to review on the next visit. If the result indicated an injury, staff should notify the doctor as soon as possible.

In an interview, DOC #143 stated that resident #012's result should be communicated to the doctor on the specified date, so that the resident could receive treatment sooner, instead of six days later. DOC #143 acknowledged there was a delay in communicating with the doctor in regards to resident #012's result. [s. 6. (4) (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 - to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, 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, to be implemented voluntarily.

WN #4: 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:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that includes any potential behavioural triggers and variations in resident functioning at different times of the day.

A CIS report was submitted to the MOHLTC on an identified date for an incident involving three residents, where resident #024 was abused by resident #025. Review of the CIS indicated on a specified date resident #026 had been screaming trying to get their device back from resident #024 who was holding it. When resident #025 overheard resident #026 was screaming they went to resident #024, grabbed them and held them in the corner. The residents were separated immediately, and resident #024 was transferred to an outside resource.

A review of resident #025's MDS assessment prior to the incident in 2017, indicated the resident had short and long term memory problem but was independent in making consistent and reasonable decisions. The resident was identified to have unpleasant mood in the morning. Behaviour was easily altered.

A review of resident #025's plan of care did not indicate what are the triggers for the resident's behaviour.

An interview with PSW #123 and #128, RPN #113, and ANM #106 indicated that most of the time the triggers for resident #025's behaviour were identified. Interviews with PSW #123 and #128, RPN #113, and ANM #106 indicated the resident had exhibited responsive behaviour towards resident #026. Every time some resident increased their voice or argued with someone, resident #025 exhibit responsive behaviour and react towards the other resident. All interviewed staff stated these triggers were not identified in the resident's plan of care and no interventions were planned to address these triggers.

An interview with Staff Development Coordinator #147 confirmed that resident #025's plan of care was not based on an interdisciplinary assessment of the resident and the above mentioned potential behavioural triggers and variations in resident functioning were not reflected in the written plan of care. [s. 26. (3) 5.]

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 responsive behaviour plan of care is based on an interdisciplinary assessment of the resident that includes any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of the following that the licensee knew of, or that was reported to the licensee, was immediately investigated:
(i) abuse of a resident by anyone,

(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulation.

A CIS report on an identified date received through the Critical Incident System, stated that resident #013 claimed the resident was hit by a staff member on an specified date.

A review of the above mentioned CIS and the home's investigation notes indicated that on the identified date, resident #013 told PSW #105 that PSW #134 hit the resident earlier that day. PSW #105 asked PSW #134 what happened. PSW #134 told PSW #105 that when PSW #134 brought resident #013's meal tray to the resident's room, PSW #134 called resident #013's name and told the resident the meal was brought to the room twice. When the resident did not respond to PSW #134's calls, PSW #134 tapped resident #103's leg. Resident #013 asked PSW #134 to get out of the room. PSW #105 asked PSW #134 to report the incident and resident #013's allegation of being hit by a staff member to the unit supervisor and the charge nurse, which was confirmed by interview with PSW #105.

PSW #134 was not available for an interview as the PSW was on a leave of absence.
Resident #013 was not available for an interview as the resident no longer resided in the home.

An interview with RN #129, who was the charge nurse for day shift on the identified date indicated that on that date PSW #134 reported an incident involving resident #013 to RN #129. Upon receiving the report, RN #129 went to see resident #013 as RN #129 thought resident #013 requested to see the charge nurse. RN #129 stated resident #013 did not raise any concerns during the meeting.

An interview with RN #132, who was the unit supervisor for day shift on the identified date, indicated that on that day, PSW #134 reported an incident to RN #132 involving resident #013. RN #132 further stated that when PSW #134 reported the incident to RN #132, RN #132 was busy at the time and forgot about the incident reported by PSW #134 afterwards. RN #132 also stated the incident reported by PSW #134 had not been followed up on.

An interview with Manager of Clinical Informatics (MCI) #133, who was the nurse manager at the time, stated that on the identified date staff #133 became aware of an allegation made by resident #013 that a staff member hit the resident on the

identified date. Staff #133 initiated the investigation and submitted the above mentioned CIS. Staff #133 acknowledged that when resident #013 reported the allegation to PSW #105 on the identified date, the home should have initiated the investigation immediately as required, not four days later. [s. 23. (1) (a)]

Issued on this 28 day of August 2018 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by GORDANA KRSTEVSKA (600) - (A1)

Inspection No. / No de l'inspection : 2018_462600_0010 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 008108-17, 009211-17, 014926-17, 020155-17, 021889-17, 023209-17, 024514-17, 005561-18 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Aug 28, 2018;(A1)

Licensee / Titulaire de permis : Cedarvale Terrace LTC Inc. as general partner of Cedarvale Terrace LTC Limited Partnership
c/o All Seniors Care Living Centres, 175 Bloor Street East, Suite 601, TORONTO, ON, M4W-3R8

LTC Home / Foyer de SLD : Cedarvale Terrace
429 Walmer Road, TORONTO, ON, M5P-2X9

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Adele Lopes

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

To Cedarvale Terrace LTC Inc. as general partner of Cedarvale Terrace LTC Limited Partnership, you are hereby required to comply with the following order(s) by the date (s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19(1) of the Act.
Specifically the licensee must:
a) Ensure all residents with cognitive impairment are protected from abuse by anyone.
b) Ensure the triggers are identified, interventions are developed and implemented for all responsive behaviours exhibited by any resident.
c) Ensure all interventions developed for all responsive behaviours exhibited by any resident are included in the resident's written plan of care, and the written plan of care is revised and updated when the resident's status changes.
d) Implement a monthly auditing process to ensure that interventions are developed and implemented for residents who exhibit responsive behaviours,
and the interventions are included in the resident's written plan of care, and the
written plan of care is revised and updated when the resident's status changes.
d) Maintain a written record of audits conducted. The written record must include
the date, the resident's name, staff member's name, the name of the person completing the audit and the action taken from the outcome of the audit.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A Critical Incident Report (CIS) was submitted to the MOHLTC on an identified date about an incident that happened on a specified date regarding an inappropriate behaviour of resident #027 towards resident #028. Review of the LTCH Inquiry and Intake information record indicated the home had submitted a CIS on another specified date for the same residents concerning the same issue.

A review of the CIS indicated that on the identified date resident #028 was found in resident #027's room beside the bed. Resident #027 was sitting on the floor in front of the bed, with no undergarment. Resident #028 was standing in front of resident #027. Resident #027 was seen inappropriately touching resident #028 with their hand.

A review of the previous CIS indicated seven days earlier, resident #027 was found in their bed standing over resident #028. In both incidents the residents were separated, taken to their rooms and placed on safety checks.

A review of resident #028's health record indicated the resident had cognitive impairment and increased CPS score. The staff was aware of the resident's identified responsive behaviour and safety check every 15 minutes was set in the plan of care for staff to monitor the resident and to keep the resident in a safe environment.

A review of resident #027's health record indicated the resident had a cognitive impairment with identified responsive behaviour, and set up interventions for staff to follow. However the resident had not exhibited verbal or physical behaviour towards resident #028. They treated resident #028 as familiar person and they kept visiting resident #028's room, until staff confronted them to stop.

An interview with PSWs #150 and #151 indicated they check the resident according to the schedule but resident #028 kept exhibiting the identified behaviour. The staff also indicated that resident #027 would enter in and out of resident #028's room until the staff told them that was not appropriate and they stopped visiting resident #028.

An interview with ANM #106 stated resident #028 had cognitive impairment and was not able to give consent. The ANM confirmed in this case, the home had not protected resident #028 from abuse. (600)

2. The licensee has failed to ensure that resident #024 was protected from abuse by anyone in the home.

For the purposes of the definition of physical abuse O. Reg. 79/10, subsection 2 (1) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

A CIS report was submitted to the MOHLTC on an identified date for an incident of resident to resident physical abuse that happened on a specified date.

A review of the CIS incident indicated involvement of residents #024, #025, and #026. On an identified date in 2017, in the TV lounge, resident #024 was taking away the assistive device of resident #026. Resident #026 was screaming and trying to get the device back, as resident #024 was pulling the device aside. Resident #024 then lifted up their hand as they were trying to hit resident #026. When resident #025 heard resident #026 screaming and saw resident #024's hand up, they went to resident #024, took their hand, grabbed them and held them in the corner. Residents were separated immediately. Residents #025 and #026 were stable, and placed on monitoring check. According to the staff interview with resident #025, resident #026 was not hit, however resident #024 sustained altered skin integrity. Resident #024 was transferred to outside resources and returned on an identified date, with an identified medical diagnosis. The team continued to follow up with the residents.

An interview with resident #025 indicated that they were irritated by the screaming voice of resident #026 and the loud voice of resident #024 who was yelling at resident #026. The resident confirmed that they approached resident #024, grabbed them on their shirt, "threw" them in the corner as resident #024 would not stop talking and disturbing resident #026.

A review of resident #024's plan of care indicated the staff had identified resident #024 exhibited responsive behaviour and although the triggers were unpredictable, the plan of care was set for staff to address the behaviour at any time. The resident

was referred to outside resources for further assessments and treatments. At the time of inspection the resident was discharged from the home as they were still outside the home.

An interview with PSW #123, RPN #108 and the Staff Development Coordinator (SDC) indicated that resident #024's behaviour had been managed most of the time. Resident #025 was known to staff to prefer a certain environment. The resident was identified to have a certain resident that they would spend time. The yelling of resident #024 and the screaming of resident #026 triggered resident #025's responsive behaviour.

A interview with Staff development coordinator confirmed resident #024 was physically abused by resident #025. (600)

3. The licensee has failed to ensure that resident #021 was protected from abuse by anyone.

For the purposes of the definition of sexual abuse O. Reg. 79/10, subsection 2 (1) defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A CIS report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date, about an incident of abuse toward resident #021 on a specified date. The incident occurred in the resident's room which is shared room for two residents. On a specified date, PSW #128 found resident #021 lying in a bed with removed bed cover and garment . Resident #022 was standing by the bed touching resident #021 inappropriately.

A review of Minimum Data Set (MDS) assessment record on an identified date, indicated resident #021 was mostly bed-fast, with cognitive impairment and increased Cognitive Performance Scale (CPS) score. Resident #022 was ambulatory, with modified independence for decision-making and low CPS score.

During interviews PSW #122 and RN #113 stated they had not seen resident #022 exhibiting identified behaviours towards residents. Further the interviewees indicated

they were surprised by resident #022's action as the resident had never exhibited identified behaviours before, and resident #021 would not be able to give consent. However the RN stated that in this case, resident #021 had been abused by resident #022.

An interview with PSW #128 confirmed that on a specified date, they found resident #022 standing over resident #021. The PSW confirmed that resident #021 was inappropriately touched by resident #022 indicating abuse.

Resident #021 was discharged from the home after this incident. An interview with resident #022 indicated no recollection of the incident.

A review of the home's clinical census record indicated that the home had not implemented the recommendation made by external resource teams of moving rooms/ roommate if current roommate is vulnerable and cannot speak for themselves.

An interview with Nurse Manager #106 and the Director of Care confirmed resident #022 did not have a history to indicate abusive behaviour, however on a specified date, resident #022 performed non-consensual inappropriate touching towards resident #021.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm/risk to residents #021, resident #024, and resident #028. The scope of the issue was a 3 as three residents were affected. The home had a level 4 history of on-going noncompliance with this section of the Act that included:
- Voluntary Compliance Plan (VPC) issued March 29, 2017, (2017_641513_0006) (600)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Dec 28, 2018(A1)

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

(A1)
The licensee must be compliant with s. 53. (4). (b)

Specifically the licensee must:
a) Ensure the strategies are developed and implemented for all responsive behaviours exhibited by any resident.
b) Ensure that if the strategies developed for any responsive behaviours exhibited by any resident are not feasible, alternatives must be developed and included in the resident's written plan of care, and to be implemented.
c) Implement an on-going auditing process to ensure that interventions are developed and implemented for residents who exhibit responsive behaviours, and the interventions are included in the resident's written plan of care, and the written plan of care is revised and updated when the resident's status changes.
d) Maintain a written record of audits conducted. The written record must include the date, the resident's name, staff member's name, the name of the person completing the audit and the action taken as a result of the audit outcome.

Grounds / Motifs :

1. The licensee has failed to ensure that strategies that had been developed were implemented to respond to the resident demonstrating responsive behaviours, where possible.

A CIS report #2591-000021-17, was submitted to the MOHLTC on July 12, 2017, about an incident on July 11, 2017, for abuse toward resident #021. The incident occurred in the resident's room which was shared between two residents. On July 11, 2017, PSW #128 found resident #021 lying in bed with removed bed cover and incontinent product. Resident #022 was standing by the bed with their hand on the resident #021's private area performing motions and talking to resident #021.

A review of resident #022's health record indicated the following:
- On June 9, 2017, PSW #128 found resident #021 in bed with no incontinent product, and resident #022 stated to the PSW that they were changing resident #021's incontinent product, later found in the washroom garbage bag. Resident #022 was referred to GMHOT and was assessed on June 12, 2017. One of the recommendations of the GMHOT was the home to consider moving rooms/ roommate if current roommate was vulnerable and cannot speak for themselves.
- On June 26, 2017, resident #022 was found without pants or incontinent product sitting on their bed and holding resident #021's bed rails, talking to resident #021. The resident stated to PSW #128 they talked to resident #021 as they like to be touched all over. Resident #021 had the incontinent product wide opened.
- On July 11, 2017, PSW #128 found resident #021 lying in bed, their bed cover and incontinent product removed. Resident #022 was standing by the bed with their hand on the resident #021's private area performing motions and talking to resident #021.
- On July 17, 2017, resident #022 was observed in the TV lounge to be rubbing resident #021's hand.

Resident #022 was referred to the BSRTL team for assessment the same day and the resident was assessed. One of the recommendations from the BSRTL team was again for the home to consider a room transfer moving one of the residents.

A review of the home's clinical census record indicated that the home had not implemented the recommendation of the GMHOT from June 12, 2017, and BSRTL team from July 17, 2017, of moving rooms/ roommate if current roommate is

vulnerable and cannot speak for themselves.

An interview with Staff development coordinator #147 indicated all interventions recommended by the GMHOT and BSRTL had been followed by the staff the best possible way. However the transfer of residents from one room to another was up to the management level to proceed with and it was not easy considering other residents' demands.

An interview with DOC indicated the home was aware of the recommendations of GMHOT and the interdisciplinary team had discussed together to make sure they follow up with the recommendation, but the DOC was not able to explain why the transfer of the residents as a plan of care was not provided when recommended.

The DOC confirmed that the strategy for transferring resident #022 as planned by the GMHOT was not implemented by the home.

The severity of this issue was determined to be a level 2 with minimal harm/risk or potential for actual harm/risk to resident #021, however due to triggered key risk indicator the severity was elevated to level 3, the scope was determined to be a level 1 as it related only to resident #021, and the previous compliance history was determined to be a level 2 as there was unrelated non-compliance in the last 36 months. (600)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Dec 28, 2018(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 28 day of August 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by GORDANA KRSTEVSKA - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Service Area Office / Bureau régional de services : Toronto