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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 18, 2018	2018_644507_0015	023667-17	Complaint

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

STELLA NG (507)

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): June 22, 25, 26, 27 & 28, August 28 & 29, 2018.

Log #023667-17 related to an allegation of abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Nurse Manager (NM), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Home Physician (HP), the Coroner and the substitute decision-maker (SDM).

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 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. 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 #001 was not neglected by staff.

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) on an identified date in regard to resident #001's care.

In an interview, resident #001's substitute decision-maker (SDM) stated that resident #001 was not feeling well, observed a change to an identified part of the resident's body and was sent to the hospital on an identified date. Resident #001's SDM further stated that the resident died in the hospital on the same day, and the SDM was concerned about the care that resident #001 received in the home.

Record review of resident #001's health record indicated the resident was admitted to the home on an identified date with specific diagnoses.

Record review of the identified Coroner's Investigation Statement (CIS) for resident #001 indicated that resident #001's medical cause of death was a specific medical condition, due to/ as a consequence of two identified health conditions (health condition A and health condition B). The contributing factors were two other identified medical diagnoses.

In interviews, staff #106 and #110 stated that they had seen a change to an identified part of the resident's body from time to time during resident #001's stay in the home, but they had not reported the observation to the registered staff. Both staff #106 and #110 stated resident #001 would tell the nurse if they were not feeling well.

Record review of resident #001's progress notes for a period of three years in relation to resident #001's health condition B, showed that on an identified date, approximately eight months prior to the resident's passing, staff #111 documented an assessment was completed and the above mentioned health condition B was observed.

In an interview, staff #111 stated that on the above mentioned date was their first time observing resident #001's health condition B. Staff #111 asked the resident about the health condition B, and resident #001 stated it came and went. Staff #111 further stated that prior to the above mentioned identified date, staff thought resident #001 might have health condition B, but not 100 per cent sure. When staff #111 was asked whether further assessment was conducted for resident #001 when the staff observed the resident's health condition B, staff #111 stated that resident #001 would tell staff how they felt. The resident could express their needs. Staff #111 stated that a note was written in the communication book for the doctor to assess during the next doctor's round.

Record review of the progress notes for resident #001 showed that resident #001's

attending physician #105 documented on the next day that there were no issues. In an interview, staff #105 stated they were not aware resident #001 had health condition B. Staff #105 further stated that if the discovery of health condition B was communicated to the attending physician, they would certainly look into it.

In an interview, staff #113 stated that they were aware resident #001 used to have health condition B, which staff #113 was not sure of the exact diagnoses. Staff #113 further stated they did not remember seeing health condition B for resident #001, and they did not remember whether the condition of resident #001's health condition B was mentioned during shift reports.

In an interview, staff #115 stated that when a new health condition was observed, staff should document the condition in the progress notes. If the health condition warranted further assessment, staff should notify the doctor by calling the doctor if the condition was urgent, or document in the doctor's communication book at the nursing station, so that the doctor could assess the resident in the next visit. After reviewing resident #001's electronic record on PointClickCare (PCC), staff #115 stated there was no further assessment or follow up that had been completed in regard to resident #001's health condition B.

In interviews, staff #102 and #103 stated that they asked the residents about a specific activity of daily living (ADL) during their shift, every shift and documented on the Point of Care (POC). Staff #102 and #103 further stated that usually the registered staff would ask them whether their assigned residents engaged in this ADL or not during their shift. The registered staff also had access to their documentation on POC. If a resident had not engaged in this ADL for two to three days, the registered staff might give the resident medication. Staff #102 stated that people who developed an identified condition might not be in their mood, sometimes the individuals might be aggressive, agitated and had no appetite to eat. Staff #103 stated it was not normal when a person did not engage in this ADL for two days and it would make the person feel uncomfortable.

Record review of the documentation survey report for the month of resident #001's passing showed that the resident engaged in this ADL on an identified date, and the resident did not engage in this ADL for the following five days. Further record review of the progress notes for resident #001 for the above mentioned five days period indicated the resident was unwell and experiencing symptoms. Resident #001 was sent to the hospital for further assessment on the fifth day.

In an interview, staff #104 stated that if a resident did not engage in this ADL for two days, the resident would be given an intervention. In addition, the resident would have a medication regime for the identified condition. The medication regime would be indicated in the resident's electronic medication administration record (eMAR). Staff #104 further stated they would be concerned if a resident did not engage in this ADL for two days. If the resident did not have the medication regime in the doctors' order or the eMAR, the attending physician would be contacted for directions.

Record review of the eMAR for the month of resident #001's passing and doctor's orders in PCC for resident #001 did not include a medication regime for the identified condition.

In an interview, staff #104 stated they were not concerned in regard to resident #001's changed health condition two days prior to the hospital, despite the resident was exhibiting symptoms. Staff #104 further stated that resident #001 did not complain of any discomfort to the nursing staff on that day. Resident #001 would inform staff if they were not well, and resident #001 had been monitored.

In an interview, staff #115 stated that resident's individualized directive for the identified ADL should have been included in the doctor's orders in PCC, or in the eMAR. PSWs were to document residents' activity on the POC. If a resident did not engage in this activity for 48 hours, the information would generate an alert on the clinical dashboard of the PCC to alert staff. Staff should administer medication to the resident according to the eMAR. If there were no directives in the eMAR, staff should contact the doctor for directions. This was not done for resident #001. Staff #115 further stated that when a resident was not feeling well and not eating well, staff should review previous progress notes and conduct assessments to find out the cause which made the resident unwell. If the resident's condition remained unchanged for three days, staff should send a referral to the Registered Dietitian for an assessment in regard to poor appetite, notify the attending physician by calling the physician for directions, and conduct nursing assessments. If a resident experienced an identified symptom, an assessment was needed. These were not done for resident #001 when the resident experienced identified symptoms between the above mentioned period.

The findings in this report is further evidence to support the order issued on July 20, 2018 , during a complaint inspection 2018_751649_0011 to be complied October 23, 2018. [s. 19. (1)]

Additional Required Actions:

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

Issued on this 9th day of October, 2018

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

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

Ministére 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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	STELLA NG (507)
Inspection No. / No de l'inspection :	2018_644507_0015
Log No. / No de registre :	023667-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 18, 2018
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

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:

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

Ministére 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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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) Develop and implement a process to ensure all new health conditions for all residents are communicated to the multidisciplinary team members.
b) Develop and implement a process to ensure assessments are conducted for any new health condition for all residents.
c) Implement an on-going auditing process to ensure that all new health conditions for all residents are communicated to the multidisciplinary team members and assessments are conducted.
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 outcome of the audit.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #001 was not neglected by staff.

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) on an identified date in regard to resident #001's care.

In an interview, resident #001's substitute decision-maker (SDM) stated that resident #001 was not feeling well, observed a change to an identified part of the resident's body and was sent to the hospital on an identified date. Resident #001's SDM further stated that the resident died in the hospital on the same day, and the SDM was concerned about the care that resident #001 received in the home.

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In an interview, staff #111 stated that on the above mentioned date was their first time observing resident #001's health condition B. Staff #111 asked the resident about the health condition B, and resident #001 stated it came and went. Staff #111 further stated that prior to the above mentioned identified date, staff thought resident #001 might have health condition B, but not 100 per cent sure. When staff #111 was asked whether further assessment was conducted for resident #001 when the staff observed the resident's health condition B, staff #111 stated that resident #001 would tell staff how they felt. The resident could express their needs. Staff #111 stated that a note was written in the communication book for the doctor to assess during the next doctor's round.

Record review of the progress notes for resident #001 showed that resident #001's attending physician #105 documented on the next day that there were no issues. In an interview, staff #105 stated they were not aware resident #001 had health condition B. Staff #105 further stated that if the discovery of health condition B was communicated to the attending physician, they would certainly look into it.

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two days, the resident would be given an intervention. In addition, the resident would have a medication regime for the identified condition. The medication regime would be indicated in the resident's electronic medication administration record (eMAR). Staff #104 further stated they would be concerned if a resident did not engage in this ADL for two days. If the resident did not have the medication regime in the doctors' order or the eMAR, the attending physician would be contacted for directions.

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The severity of this non-compliance was identified as actual harm or risk, the scope was identified as isolated. Review of the home's compliance history

revealed that a voluntary plan of correction (VPC) was issued on May 8, 2017, under inspection report #2017_641513_0006 for non-compliance with the LTCHA, 2007 O.Reg. 79/10, s.19 (1). Due to the severity of actual harm or risk and previous non-compliance with a VPC a compliance order is warranted. (507)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 23, 2018

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

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

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 18th day of September, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Ministére 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

Name of Inspector / Nom de l'inspecteur : STELLA NG

Service Area Office / Bureau régional de services : Toronto Service Area Office