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 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 31, 2019	2019_644507_0001	028326-18, 029682-18	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): January 9, 10, 14, 15, 16, 17, 18, 21, 22 (off-site interview), 23 and 24, 2019.

The following complaint was inspected during this inspection:
#029682-18 related to unknown cause of an injury.

The following critical incident report was inspected during this inspection:
#028326-18 (CIS #2591-000040-18) related to unknown cause of an injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Staff Development Coordinator (SDC), Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Home Physician, Physiotherapist (PT), Rehabilitation Therapist, Coroner, Private Care Giver and substitute decision maker (SDM).

The inspector conducted observations of staff and resident interactions, provision of care, record review of resident and home records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 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	Légende 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).

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 assessment of the resident so that their assessments were integrated and were consistent with and complement each other.

On an identified date, the Ministry of Health and Long-Term Care (MOHLTC) received a complaint in regard to the unknown cause of resident #001's injury.

In an interview, resident #001's substitute decision-maker (SDM) stated that the family was informed of the resident's injury on an identified date by the home. The family was also informed at a later date that the home conducted the investigation and was not able to determine the cause of the injury as the resident did not experience any accident prior to the discovery of the injury.

An identified critical incident system (CIS) report was submitted to the MOHLTC on an identified date stated that three days prior at an approximate time, staff #118 noticed that resident #001 was in an identified health condition during provision of care. Staff #109 was called to assess the resident. Upon assessment, resident #001 was observed as having identified health conditions. Resident #001 was sent to the hospital for further assessment. Resident #001 was diagnosed with an identified injury and received interventions two days later. Resident #001 returned to the home after nine days and then passed away four days after returning to the home. This was confirmed during an interview with staff #109.

Review of resident #001's physiotherapy quarterly assessment completed approximately 10 weeks prior to the discovery of the injury by staff #114 indicated the resident was

independent in bed mobility and transfers with the use of transfer aides and required supervision for ambulation.

Review of resident #001's Resident Assessment Instrument - Minimum Data Set (RAI-MDS) completed approximately ten days prior to the discovery of the injury indicated the resident required supervision for bed mobility, transfers, walking in the room, walking in the corridor and locomotion on unit. The RAI-MDS also indicated the resident did not require any mobility assistive device, and the resident required the use of transfer aides for bed mobility and transfers.

Review of resident #001's written plan of care completed on the same day as the above mentioned RAI-MDS indicated the resident required one person assistance and the use of transfer aides for support during transfer. Resident #001 was at risk for falls related to their identified health conditions and required one person assistance for walking and ambulation on the unit without any mobility assistance device. A mobility device was required for long distance locomotion off the unit or when the resident experiencing specified health conditions.

Review of the home's investigation notes in regard to resident #001's injury indicated that during an interview, staff #120 told staff #107 that resident #001 had identified health conditions the day before the injury was discovered. This was confirmed during an interview with staff #107.

In an interview, staff #120 told the inspector that staff #120 observed resident #001's ability of ambulation and transfer decreased the day before the injury was discovered, in comparison to two weeks prior. Staff #120 also observed resident #001 experiencing an identified health condition during provision of care. Staff #120 told the inspector that resident #001's above mentioned change of health condition was not reported to the registered staff. This was confirmed by reviewing the progress notes for resident #001 and interviewing with staff #123.

In an interview, staff #107 stated that staff #120 should have reported to the registered staff when resident #001's health condition was changed, so that assessment and/ or interventions could have been conducted and/ or implemented. [s. 6. (4) (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 the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The Licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

On an identified date, the MOHLTC received a complaint in regard to the unknown cause of resident #001's injury.

In an interview, resident #001's SDM stated that the family was informed of the resident's injury on an identified date by the home. The family was also informed at a later date that the home conducted the investigation and was not able to determine the cause of the injury as the resident did not experience any accident prior to the discovery of the injury.

An identified critical incident system (CIS) report was submitted to the MOHLTC on an identified date stated that three days prior at an approximate time, staff #118 noticed that resident #001 was in an identified health condition during provision of care. Staff #109 was called to assess the resident. Upon assessment, resident #001 was observed as having identified health conditions. Resident #001 was sent to the hospital for further assessment. Resident #001 was diagnosed with an identified injury and received interventions two days later. Resident #001 returned to the home after nine days and then passed away four days after returning to the home. This was confirmed during an interview with staff #109.

Review of resident #001's physiotherapy quarterly assessment completed approximately 10 weeks prior to the discovery of the injury by staff #114 indicated the resident was independent in bed mobility and transfers with the use of transfer aides and required supervision for ambulation.

Review of resident #001's Resident Assessment Instrument - Minimum Data Set (RAI-MDS) completed approximately ten days prior to the discovery of the injury indicated the resident required supervision for bed mobility, transfers, walking in the room, walking in the corridor and locomotion on unit. The RAI-MDS also indicated the resident did not require any mobility assistive device, and the resident required the use of transfer aides for bed mobility and transfers.

Review of resident #001's written plan of care completed on the same day as the above mentioned RAI-MDS indicated the resident required one person assistance and the use of transfer aides for support during transfer. Resident #001 was at risk for falls related to their identified health conditions and required one person assistance for walking and ambulation on the unit without any mobility assistance device. A mobility device was required for long distance locomotion off the unit or when the resident experiencing specified health conditions.

Review of resident #001's progress notes and the home's investigation notes indicated that the day before the discovery of the injury, staff #118 walked resident #001 to the dining room for meal service after assisting the resident with personal care. Resident #001 was seen ambulating independently on the unit after meal service. At an approximate time, staff #117 went to resident #001's room and assisted resident #001 up from bed for meal service. Staff #117 had to use a mobility device to take the resident to the dining room due to an identified health condition. After meal service, staff #117 sat resident #001 in the lounge by the nursing station for monitoring. Resident #001 remained in the chair in the lounge when staff #117 ended the shift approximately two hours later. This was confirmed by interviews with staff #117, #118, and #109.

In an interview, staff #120 stated when they came on duty the day before the discovery of the injury at an identified time, resident #001 was sitting in a chair in the lounge by the nursing station. Staff #120 stated that resident #001 was taken to the dining room for meal service in a mobility device. Staff #120 placed resident #001 in the lounge by the nursing station after meal service for monitoring. At an approximate time, staff #120 told staff #123 that they were going to put resident #001 to bed. Staff #120 told the inspector

that resident #001's ability to stand and transfer was decreased from two weeks prior. Staff #120 then lifted the resident from the chair and sat the resident in bed. Staff #120 further stated that resident #001 was observed to experience an identified health condition during provision of care. Staff #120 told the inspector that on the day prior to the discovery of the injury, at an approximate time, they were aware that resident #001's decreased ability in assisting with transfers, and staff #120 transferred the resident without assistance from another co-worker.

In an interview, Staff #125 stated the safe transfer training included the falls prevention and safe resident handling policies. When conducting the trainings, staff #125 would tell staff to perform the transfer safely and call for help if needed. Staff #125 further stated it was a common rule not to transfer a resident without assistance from another co-worker if the resident was not able to assist with the transfer.

In an interview, staff #114 stated the usual recommendation for transferring a resident who was not able to assist with the transfer and required a mechanical lift with two people assistance. Staff should not transfer a resident without assistance from another co-worker if the resident was not able to assist for the transfer for the safety of the resident and staff.

In an interview, staff #107 stated that all staff were aware not to transfer a resident who was not able to assist with transfer without assistance from another co-worker. [s. 36.]

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 use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 6th day of February, 2019

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

Original report signed by the inspector.