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

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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
May 14, 2019	2019_493652_0008 (A1)	011645-18, 018050-18, 000587-19, 003824-19, 005452-19, 006128-19	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 NATALIE MOLIN (652) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The Licensee has been granted an extension to the compliance order date. The new compliance order date is June 28, 2019.

Issued on this 14th day of May, 2019 (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

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*

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

Amended by NATALIE MOLIN (652) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 28 and April 1, 2, 3, 9, 10, 2019.

The following critical incident system (CIS) inspections were conducted:

Log # 000587-19 related to prevention of abuse and neglect.

Log #00612 8-19 related to missing resident

Log #0 03824 -19 and 011645-18 related to resident to resident abuse

Log #018050-18 related to restraints

Log #005452-19, CIS #2591-000006019 related to resident to resident abuse

During the course of the inspection, the inspector(s) spoke with the director of care (DOC), nurse managers (NM), registered nursing staff, personal support worker (PSWs), housekeeper.

During the course of the inspection, the inspector(s) conducted a tour of the home; observed staff to resident interactions and the provision of care, reviewed the home's investigations, conducted records review and staff interviews

The following Inspection Protocols were used during this inspection:

Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of the original inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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	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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1.The licensee has failed to ensure that staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The home submitted a Critical Incident System (CIS) report on an identified date related to resident to resident physical abuse by resident #013 towards resident #014.

A review of resident #013's plan of care at the time of the inspection indicated they were on safety checks to manage the resident's behavioural responses. The plan of care directed PSWs to check the resident's whereabouts every hour.

In an interview, PSW #115 indicated that resident #013 had a history of behavioural symptoms towards co-residents. The PSW indicated they were not aware that resident #013 was on hourly safety checks. PSW #115 stated they were busy at the start of an identified shift and did not look at the resident's plan of care, until it was brought up to their attention by the inspector. PSW #115 stated that they don't usually work in the resident home area and was to have

reviewed the care plan at the start of their shift, but didn't. The PSW indicated that it is important to know the plan of care of resident #013 to ensure safety of the residents.

In an interview, the DOC indicated that it is the home's process for PSW staff to review the kardex at the beginning of their shift. The DOC stated that if a PSW does not work in the resident home area often, the unit nurse would need to remind the PSW the residents that are high risk and required monitoring. The DOC indicated that PSW #115 should have been aware of resident #013's plan of care regarding the hourly safety checks as the resident required monitoring.

2. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

The home submitted a CIS report to the MOHLTC for an incident that occurred on an identified date, related to resident to resident abuse. PSW #127 observed resident #016 and resident #015 engaged in an activity and redirected resident #016. Five minutes later, a loud noise was heard and PSWs #128 ad #129 found resident #016 injured and resident #017 stated resident #016 and #015 were engaged in an activity. Resident #016 was redirected.

A review of the written plan of care for resident #017 indicated that they had a history of behavioural responses towards co-residents. The plan of care at the time of the incident indicated the need for safety checks related to the behavioural responses towards co-resident and directed staff to check the resident's whereabouts every shift.

A review of the documentation survey report for an identified date, had a task to check every shift to ensure safety. The report did not have documentation by the PSWs on identified dates and wasn't documented on an identified shift.

In an interview, PSW #128, indicated that it is the home's process for PSWs to document the tasks completed for their residents. PSW #128 stated that they were aware that resident #017 required safety checks and had visually checked on the resident during an identified shift and date. The PSW acknowledged they did not document the care provided to resident #017.

In an interview, NM #105 reviewed the documentation survey report and indicated that the PSW may not have documented the safety checks for resident #017 or

did not conduct the safety checks. The NM acknowledged that it was important to document safety checks on residents as part of their plan of care so that the risk of incidents will be mitigated and to protect the resident themselves and/or other residents.

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan had not been effective.

The home submitted a CIS report to MOHLTC on an identified date, related to resident to resident physical abuse. The CIS report indicated that on an identified date, RPN #112 observed resident #014 standing close to resident #013's room. Resident #013 was ambulating with their mobility device and approached resident #014 and told them to get out of the way. RPN #112 observed resident #013 push resident #014 who fell to the ground and sustained an injury.

A review of resident #014's plan of care at the time of the CIS indicated that the resident had the behavioural responses and ambulated independently without a mobility device. Interventions to manage the resident's behavioural responses included: allow the resident to move around on the unit, redirect and safety checks by checking the resident's whereabouts every shift.

A review of the progress notes and the hospital discharge summary indicated that resident #014 was transferred to hospital on an identified date, underwent a medical procedure and returned to the home on an identified date, and used a mobility device at the time of the inspection.

A review of the CIS report indicated that resident #013 had a history of behavioural responses towards co-residents. There had been three incidents over the past six months where resident #013 exhibited behavioural responses towards co-residents. On an identified date, resident #004 went into resident #013's room and was injured on an identified body part by resident #013. On another identified date, resident #013 was seen pushing their mobility device towards resident #004. The unit staff intervened and redirected resident #004.

A review of resident #013's written plan of care at the time of incident, indicated that the resident was on safety checks related to identified behavioural responses. Interventions were initiated at the time of the incident and staff were directed to check resident #013's whereabouts every hour for safety.

In interviews, RN #113, RPN #112 and PSW #115 indicated that resident #013 had a history of behavioural symptoms towards co-residents. Resident #013 did not like when co residents invaded their personal space and would exhibit behavioural responses towards co-residents. Interventions to manage resident #013's behavioural responses included a yellow wander guard strip across their doorway and hourly safety checks. RN #113 indicated that the yellow wander guard strip was implemented on an identified date.

In an interview RPN #112 verified that a yellow wander guard strip and hourly safety checks were interventions to deter co- residents from entering the room and manage resident #013's behavioural responses .The RPN did not recall if the yellow wander guard strip was in place for resident #013 at the time of the incident and was not sure if resident #014 was able to remove the yellow wander guard strip. RPN #112 indicated that they were not sure if it was a very effective intervention since resident #014 sustained an injury when they went into resident #013's room. The RPN further stated that resident #014 had safety checks every shift as an intervention to manage their behavioural responses. However, the RPN stated that the intervention was not effective and resident #013's room should have been monitored hourly.

In an interview, resident #013, indicated that co-residents entered their room and looked through their personal belongings. The resident stated when this occurs, they tell the co-residents to get out. Resident #013 denied any altercations with residents who had entered their room.

In an interview, Nurse Manager (NM) #105 indicated that both resident #014 and resident #013 demonstrated behavioural responses. The NM indicated that resident #013 had a yellow wander guard strip and was monitored hourly at the time of the incident. The yellow wander guard strip was effective, but the NM indicated that the home could have developed new interventions to further deter resident #014 and co-residents from entering resident #013's room. In the interview, NM #105 acknowledged that resident #013's plan of care was not reassessed and revised when the interventions were not effective.

4. The home submitted a CIS report to the MOHLTC for an incident that occurred on an identified date, related to resident to resident abuse.

A review of resident #016's written plan of care at the time of the incident

indicated that the resident had a history of behavioural responses towards co-residents and staff. The plan of care directed staff to conduct safety checks by checking the resident's whereabouts every 15 minutes and remove from a public area if behaviour was disruptive.

A review of resident #016's progress notes indicated that prior to the CIS, there were two documented incidents when resident #016 was found engaged in an activity with resident #014. The progress notes stated that resident #016 was redirected and was monitored.

The plan of care for resident #016 did not have documentation on new interventions after the two documented incidents on identified dates, to prevent recurrence and manage the resident's behavioural responses.

A record review of resident #016's clinical records indicated they were followed by an external consultant to manage the resident's behavioural responses. Resident #016 was assessed by the external consultant with recommendations to continue with interventions, monitor every 30 minutes for safety and medication recommendations.

A review of the physician's orders indicated the resident was ordered medical interventions to decrease resident #016's behavioural responses.

In interviews, RN #113 and PSWs #128 and #129 verified resident #016 demonstrated behavioural responses towards co-residents and frequently entered specific resident rooms. They indicated that a wander guard strip was put across the rooms and the resident was also monitored for their whereabouts every 15 minutes.

In the interview, RN #113 indicated that monitoring resident #016's whereabouts every 15 minutes to manage their behavioural responses was not effective. The home continued to monitor resident #016 by doing safety checks. The plan of care was not revised and no new interventions were implemented until after the CIS incident.

In an interview, NM #105 indicated that the safety check monitoring for resident #016 was not effective in managing the resident's behavioural responses. The NM stated that the plan of care was not revised and did not include new interventions after two identified incidents. NM #105 indicated that the home had

a discussion with the physician after the CIS incident and resident #016 was ordered medical intervention to manage their behavioural responses.

In interviews, the Administrator indicated that there were no new interventions put in place after the two identified incidents. The Administrator indicated that the staff continued to monitor resident #016 after the incidents and the plan of care was revised with an initiation of the identified medication after the CIS incident. The home therefore failed to ensure that the resident was reassessed and the plan of care was reviewed and revised when the care set out in the plan had not been effective for resident #016.

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 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 residents were protected from abuse by anyone.

Under O. Reg. 79/10, s.2 (1) for the purpose of the definition of physical abuse in subsection 2 (1) of the Act, physical abuse means (c) the use of physical force by a resident that causes physical injury to another resident.

The home submitted a CIS report to MOHLTC on an identified date, related to resident to resident physical abuse. The CIS report indicated that on an identified date, RPN #112 observed resident #014 standing in the entrance of resident #013's room. Resident #013 was ambulating with their mobility device and approached resident #014 and told them to get out of the way. RPN #112 observed resident #013 push resident #014 who fell to the ground and sustained an injury.

A review of resident #014's plan of care at the time of the CIS indicated that the resident had behavioural responses and ambulated independently without a mobility device. Interventions to manage the resident's behavioural responses included: allow the resident to move around on the unit, redirect and safety checks by checking the resident's whereabouts every shift.

A review of the progress notes and the hospital discharge summary indicated that resident #014 was transferred to hospital on identified date, underwent a medical procedure and returned to the home. A review of the written plan of care indicated that the resident's mobility status changed and used a mobility device at the time of the inspection.

A review of the CIS report indicated that resident #013 had a history of behavioural responses towards co-residents. There had been three incidents over the past six months where resident #013 exhibited behavioural symptoms responses co-residents. On an identified date, resident #004 went into resident #013's room and was injured on an identified body part by resident #013. On another identified date, resident #013 was seen pushing their mobility device towards resident #004. The unit staff intervened and redirected resident #004.

A review of resident #013's progress notes on identified dates, documented the two incidents above with resident #004. The progress notes stated that the registered staff spoke to resident #013 to call staff for help.

In interviews, RN #113, RPN #112 and PSW #115 indicated that resident #013 had a history of behavioural responses towards co-residents. Resident #013 did not like when co residents invaded their personal space and would exhibit

behavioural responses towards co-residents. Interventions to manage resident #013's behavioural responses included a yellow wander guard strip across their doorway and hourly safety checks. RN #113 indicated that the yellow wander guard strip was implemented on an identified date.

In an interview, RPN #112 indicated they had witnessed resident #013 push resident #014. The RPN stated that they were in front of an identified location and heard resident #013 say get out of my room and observed resident #013 push resident #014. RPN #112 indicated that they assessed resident #014 and found deficits in resident identified body part. The physician assessed resident #014 and was transferred to hospital.

In the interview RPN #112 stated that a yellow wander guard strip and hourly safety checks were interventions to deter co-residents from entering resident #013's room and manage their behavioural responses. The RPN did not recall if the yellow wander guard strip was in place for #013's room at the time of the incident and was not sure if resident #014 was able to remove the yellow wander guard strip. RPN indicated that they were not sure if it the yellow wander strip was an effective intervention, since resident #014 went into resident #013's room and sustained injury by resident #013. The RPN further stated that resident #014 had safety checks every shift as an intervention to manage their behavioural responses. However, the RPN stated that the intervention was not effective and should have been monitored hourly. The RPN considered the incident to be physical abuse by resident #013 towards resident #014.

In an interview, resident #013, indicated that co-residents enter their room and look through their personal belongings. The resident stated when this occurs, they tell the co-residents to get out. Resident #013 denied pushing any residents who had entered their room.

In an interview, Nurse Manager (NM) #105 indicated that resident #014 did not like anyone invading their personal space. The NM acknowledged that the home did not protect resident #014 from entering resident #013's room who was known to demonstrate behavioural responses towards co-residents. The NM indicated that resident #013 had a yellow wander guard strip and was monitored to prevent residents from entering their room at the time of the incident. The yellow wander guard strip was effective, but the NM indicated that the home could have developed new interventions to further deter resident #014 and other residents in the unit from entering resident #013's room. In the interview, NM #105 stated that

resident #014 had a significant change in status as a result of the incident. Resident #014 ambulated independently prior to the incident but now has a change in their mobility status. The NM considered the incident to be physical abuse by resident #013 towards resident #014.

2. The home submitted a CIS report to the MOHLTC for an incident that occurred on an identified date, related to resident to resident abuse.

A review of resident #015's clinical records indicated resident #015's had an identified diagnosis and cognitive level. Interviews with NM #105, RN #113 and PSW #128 indicated that resident #015 had cognitive impairment..

Resident #015 was discharged from the home at the time of the inspection.

A review of resident #016's written plan of care at the time of the incident indicated that the resident had a history of behavioural responses towards an identified group of co-residents and staff, had a history of behavioural responses towards co-residents. The plan of care directed staff to conduct safety checks by checking the resident's whereabouts every 15 minutes.

A review of resident #016's progress notes indicated that prior to the CIS, there were two documented incidents when resident #016 was found engaged in an activity with resident #014. resident on May 16 and 25, 2018. The progress notes stated that resident #016 was redirected out of the room and was monitored.

In an interview, NM #105 indicated that they spoke to the staff that was involved in the CIS. The NM acknowledged that the incident was abuse by resident #016 towards resident #015.

In an interview, PSW #128 indicated that resident #016 had a history of inappropriate behaviours towards co-residents. The PSW considered the incident to be abuse by resident #016 towards resident #015.

At the time of this inspection, PSW #127 was no longer an employee of the home. Attempts to contact the PSW was unsuccessful.

In interviews, RN #113 and PSW #129 indicated that resident #016 had behavioural symptoms towards and identified group of co-residents. Resident #016 frequently entered specific resident rooms. They indicated that a wander

guard strip was put across the rooms resident #016 frequented to prevent them from entering the room. The resident was also monitored for their whereabouts every 15 minutes to observe their behavioural symptoms.

A record review of resident #016's clinical records indicated they were followed by an external consultant to manage the resident's behavioural symptoms towards co-residents. The external consultant assessed the resident on an identified date with recommendations to continue with interventions, monitor every 30 minutes for safety and medication recommendations.

A review of the physician's orders indicated that the resident was ordered medical interventions to decrease resident #016's behavioural symptoms after the CIS incident.

A review of the plan of care for resident #016 did not have documentation on new interventions after the two documented incidents on identified dates to prevent recurrence and manage the resident's inappropriate behaviours.

In interviews, the Administrator and NM #105 indicated that there were no new interventions put in place after identified dates of the incidences to prevent resident #016's behavioural symptoms.The NM and Administrator indicated that the staff continued to monitor resident #016 after the incidents. Therefore, the home failed to ensure that resident #015 was protected from abuse by resident #016.

3. Record review of CIS report on an identified date, indicated resident #004 went into resident #005's room and the housekeeper observed resident #005 push resident #004 and they fell to the ground. Resident #004 was assessed and it was noted that their identified body part had a deficit and resident #004 was transferred to the hospital. Resident #004 sustained an injury and underwent a medical procedure.

Record review of resident #004's progress notes on an identified date, indicated resident #004 was pushed by resident #005 and resident #004 presented with an identified deficit upon assessment an as a result was transferred to hospital.

In an interview housekeeper #128 verified they witnessed resident #005 push resident #004 on an identified date and resident #004 fell to the ground.

In an interview nurse manager #105 acknowledged resident #004 was pushed by resident #005.

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.O. 2007, c.8, s. 35. Prohibited devices that limit movement
Every licensee of a long-term care home shall ensure that no device provided for in the regulations is used on a resident,
(a) to restrain the resident; or
(b) to assist a resident with a routine activity of living, if the device would have the effect of limiting or inhibiting the resident's freedom of movement. 2007, c. 8, s. 35.

Findings/Faits saillants :

1. The licensee has failed to ensure that no device provided for in the regulations is used to restrain a resident.

The home submitted a CIS report on an identified date, related to staff to resident physical abuse related to the use of a restraint on resident #011.

A review of resident #011's plan of care did not indicate that the resident used any type of prohibited device.

In an interview, RPN #106 indicated that on an identified shift and date, they observed an identified device applied to resident #011. The RPN asked PSW #108 to remove the device. The RPN stated that the identified item was a prohibited device, and had informed NM #105 of the incident.

In an interview, PSW #108 stated that the resident was prone to falls and to ensure their safety, they used the item as a restraint. In addition, the PSW indicated that they were alone in the RHA and had to monitor other residents and the use of the item as a restraint was a solution to ensure the resident's safety.

A record review of the home's investigation notes confirmed that PSW #108 used an identified item to restrain resident #011 while sitting in the mobility device.

In interviews, NM #105 and the DOC acknowledged that the identified item is a prohibited restraining device as per the LTCHA's regulations. NM #105 indicated that resident #011's plan of care did not include the use of any restraining device. Both the NM and the DOC stated that a prohibited restraining device was used to restraint resident.

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 no device provided for in the regulations is used on a resident, to restrain the resident, to be implemented voluntarily.

Issued on this 14th day of May, 2019 (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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by NATALIE MOLIN (652) - (A1)
Inspection No. / No de l'inspection :	2019_493652_0008 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	011645-18, 018050-18, 000587-19, 003824-19, 005452-19, 006128-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 14, 2019(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

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

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.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must be compliant with LTCHA, 2007. s. 6 (10) (c).

Specifically, the licensee must ensure:

1. The plan of care for residents #013 and #016, and any other resident with behavioural responses, are updated to ensure that the interventions to manage their behaviours are effective.

2. Develop an on-going audit tool to monitor the plans of care for residents #013 and #016 and any other residents with behavioural responses to ensure that interventions are effective in managing their behaviours towards co-residents. The home is required to maintain a documentation record of the audit, the date the audit is conducted, who completed the audit and the outcome of the audit and an analysis of the results.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan had not been effective.

The home submitted a CIS report to MOHLTC on an identified date, related to resident to resident physical abuse. The CIS report indicated that on an identified date, RPN #112 observed resident #014 standing close to resident #013's room. Resident #013 was ambulating with their mobility device and approached resident #014 and told them to get out of the way. RPN #112 observed resident #013 push resident #014 who fell to the ground and sustained an injury.

A review of resident #014's plan of care at the time of the CIS indicated that the resident had the behavioural responses and ambulated independently without a mobility device. Interventions to manage the resident's behavioural responses included: allow the resident to move around on the unit, redirect and safety checks by checking the resident's whereabouts every shift.

A review of the progress notes and the hospital discharge summary indicated that resident #014 was transferred to hospital on an identified date, underwent a medical procedure and returned to the home on an identified date, and used a mobility device at the time of the inspection.

A review of the CIS report indicated that resident #013 had a history of behavioural responses towards co-residents. There had been three incidents over the past six months where resident #013 exhibited behavioural responses towards co-residents. On an identified date, resident #004 went into resident #013's room and was injured on an identified body part by resident #013. On another identified date, resident #013 was seen pushing their mobility device towards resident #004. The unit staff intervened and redirected resident #004.

A review of resident #013's written plan of care at the time of incident, indicated that the resident was on safety checks related to identified behavioural responses. Interventions were initiated at the time of the incident and staff were directed to check resident #013's whereabouts every hour for safety.

In interviews, RN #113, RPN #112 and PSW #115 indicated that resident #013 had a history of behavioural symptoms towards co-residents. Resident #013 did not like when co residents invaded their personal space and would exhibit behavioural responses towards co-residents. Interventions to manage resident #013's behavioural responses included a yellow wander guard strip across their doorway and hourly safety checks. RN #113 indicated that the yellow wander guard strip was

implemented on an identified date.

In an interview RPN #112 verified that a yellow wander guard strip and hourly safety checks were interventions to deter co- residents from entering the room and manage resident #013's behavioural responses The RPN did not recall if the yellow wander guard strip was in place for resident #013 at the time of the incident and was not sure if resident #014 was able to remove the yellow wander guard strip. RPN #112 indicated that they were not sure if it was a very effective intervention since resident #014 sustained an injury when they went into resident #013's room. The RPN further stated that resident #014 had safety checks every shift as an intervention to manage their behavioural responses. However, the RPN stated that the intervention was not effective and resident #013's room should have been monitored hourly.

In an interview, resident #013, indicated that co-residents entered their room and looked through their personal belongings. The resident stated when this occurs, they tell the co-residents to get out. Resident #013 denied any altercations with residents who had entered their room.

In an interview, Nurse Manager (NM) #105 indicated that both resident #014 and resident #013 demonstrated behavioural responses. The NM indicated that resident #013 had a yellow wander guard strip and was monitored hourly at the time of the incident. The yellow wander guard strip was effective, but the NM indicated that the home could have developed new interventions to further deter resident #014 and co-residents from entering resident #013's room. In the interview, NM #105 acknowledged that resident #013's plan of care was not reassessed and revised when the interventions were not effective. (665)

2. The home submitted a CIS report to the MOHLTC for an incident that occurred on an identified date, related to resident to resident abuse.

A review of resident #016's written plan of care at the time of the incident indicated that the resident had a history of behavioural responses towards co-residents and staff. The plan of care directed staff to conduct safety checks by checking the resident's whereabouts every 15 minutes and remove from a public area if behaviour was disruptive.

A review of resident #016's progress notes indicated that prior to the CIS, there were two documented incidents when resident #016 was found engaged in an activity with

resident #014. The progress notes stated that resident #016 was redirected and was monitored.

The plan of care for resident #016 did not have documentation on new interventions after the two documented incidents on identified dates, to prevent recurrence and manage the resident's behavioural responses.

A record review of resident #016's clinical records indicated they were followed by an external consultant to manage the resident's behavioural responses. Resident #016 was assessed by the external consultant with recommendations to continue with interventions, monitor every 30 minutes for safety and medication recommendations.

A review of the physician's orders indicated the resident was ordered medical interventions to decrease resident #016's behavioural responses.

In interviews, RN #113 and PSWs #128 and #129 verified resident #016 demonstrated behavioural responses towards co-residents and frequently entered specific resident rooms. They indicated that a wander guard strip was put across the rooms and the resident was also monitored for their whereabouts every 15 minutes.

In the interview, RN #113 indicated that monitoring resident #016's whereabouts every 15 minutes to manage their behavioural responses was not effective. The home continued to monitor resident #016 by doing safety checks. The plan of care was not revised and no new interventions were implemented until after the CIS incident.

In an interview, NM #105 indicated that the safety check monitoring for resident #016 was not effective in managing the resident's behavioural responses. The NM stated that the plan of care was not revised and did not include new interventions after two identified incidents. NM #105 indicated that the home had a discussion with the physician after the CIS incident and resident #016 was ordered medical intervention to manage their behavioural responses.

In interviews, the Administrator indicated that there were no new interventions put in place after the two identified incidents. The Administrator indicated that the staff continued to monitor resident #016 after the incidents and the plan of care was revised with an initiation of the identified medication after the CIS incident. The home

therefore failed to ensure that the resident was reassessed and the plan of care was reviewed and revised when the care set out in the plan had not been effective for resident #016.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident
The scope of the issue was a level 1 as it was isolated related to the residents that were reviewed. The home had a level 2 history of previous unrelated non compliance.
(665)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 28, 2019(A1)

Order # / Ordre no : 002

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 LTCHA, 2007, s. 19 (1)

Specifically, the licensee must ensure:

1. That resident #014 is protected from abuse by resident #013, and by other co-residents who exhibits responsive behaviours.

2. That residents are protected from abuse by resident #016.

3. Update the plan of care for residents #013 and #016, to include interventions and/or strategies to protect resident #014 and any other resident from abuse.

4. Develop a process to monitor residents who exhibits identified behaviour to prevent altercations with co-residents.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

Under O. Reg. 79/10, s.2 (1) for the purpose of the definition of physical abuse in subsection 2 (1) of the Act, physical abuse means (c) the use of physical force by a resident that causes physical injury to another resident.

The home submitted a CIS report to MOHLTC on an identified date, related to

resident to resident physical abuse. The CIS report indicated that on an identified date, RPN #112 observed resident #014 standing in the entrance of resident #013's room. Resident #013 was ambulating with their mobility device and approached resident #014 and told them to get out of the way. RPN #112 observed resident #013 push resident #014 who fell to the ground and sustained an injury.

A review of resident #014's plan of care at the time of the CIS indicated that the resident had behavioural responses and ambulated independently without a mobility device. Interventions to manage the resident's behavioural responses included: allow the resident to move around on the unit, redirect and safety checks by checking the resident's whereabouts every shift.

A review of the progress notes and the hospital discharge summary indicated that resident #014 was transferred to hospital on identified date, underwent a medical procedure and returned to the home. A review of the written plan of care indicated that the resident's mobility status changed and used a mobility device at the time of the inspection.

A review of the CIS report indicated that resident #013 had a history of behavioural responses towards co-residents. There had been three incidents over the past six months where resident #013 exhibited behavioural symptoms responses co-residents. On an identified date, resident #004 went into resident #013's room and was injured on an identified body part by resident #013. On another identified date, resident #013 was seen pushing their mobility device towards resident #004. The unit staff intervened and redirected resident #004.

A review of resident #013's progress notes on identified dates, documented the two incidents above with resident #004. The progress notes stated that the registered staff spoke to resident #013 to call staff for help.

In interviews, RN #113, RPN #112 and PSW #115 indicated that resident #013 had a history of behavioural responses towards co-residents. Resident #013 did not like when co residents invaded their personal space and would exhibit behavioural responses towards co-residents. Interventions to manage resident #013's behavioural responses included a yellow wander guard strip across their doorway and hourly safety checks. RN #113 indicated that the yellow wander guard strip was implemented on an identified date.

In an interview, RPN #112 indicated they had witnessed resident #013 push resident #014. The RPN stated that they were in front of an identified location and heard resident #013 say get out of my room and observed resident #013 push resident #014. RPN #112 indicated that they assessed resident #014 and found deficits in resident identified body part. The physician assessed resident #014 and was transferred to hospital.

In the interview RPN #112 stated that a yellow wander guard strip and hourly safety checks were interventions to deter co-residents from entering resident #013's room and manage their behavioural responses. The RPN did not recall if the yellow wander guard strip was in place for #013's room at the time of the incident and was not sure if resident #014 was able to remove the yellow wander guard strip. RPN indicated that they were not sure if it the yellow wander strip was an effective intervention, since resident #014 went into resident #013's room and sustained injury by resident #013. The RPN further stated that resident #014 had safety checks every shift as an intervention to manage their behavioural responses. However, the RPN stated that the intervention was not effective and should have been monitored hourly. The RPN considered the incident to be physical abuse by resident #013 towards resident #014.

In an interview, resident #013, indicated that co-residents enter their room and look through their personal belongings. The resident stated when this occurs, they tell the co-residents to get out. Resident #013 denied pushing any residents who had entered their room.

In an interview, Nurse Manager (NM) #105 indicated that resident #014 did not like anyone invading their personal space. The NM acknowledged that the home did not protect resident #014 from entering resident #013's room who was known to demonstrate behavioural responses towards co-residents. The NM indicated that resident #013 had a yellow wander guard strip and was monitored to prevent residents from entering their room at the time of the incident. The yellow wander guard strip was effective, but the NM indicated that the home could have developed new interventions to further deter resident #014 and other residents in the unit from entering resident #013's room. In the interview, NM #105 stated that resident #014 had a significant change in status as a result of the incident. Resident #014 ambulated independently prior to the incident but now has a change in their mobility

status. The NM considered the incident to be physical abuse by resident #013 towards resident #014. (665)

2. The home submitted a CIS report to the MOHLTC for an incident that occurred on an identified date, related to resident to resident abuse.

A review of resident #015's clinical records indicated resident #015's had an identified diagnosis and cognitive level. Interviews with NM #105, RN #113 and PSW #128 indicated that resident #015 had cognitive impairment..

Resident #015 was discharged from the home at the time of the inspection.

A review of resident #016's written plan of care at the time of the incident indicated that the resident had a history of behavioural responses towards an identified group of co-residents and staff, had a history of behavioural responses towards co-residents. The plan of care directed staff to conduct safety checks by checking the resident's whereabouts every 15 minutes.

A review of resident #016's progress notes indicated that prior to the CIS, there were two documented incidents when resident #016 was found engaged in an activity with resident #014. resident on May 16 and 25, 2018. The progress notes stated that resident #016 was redirected out of the room and was monitored.

In an interview, NM #105 indicated that they spoke to the staff that was involved in the CIS. The NM acknowledged that the incident was abuse by resident #016 towards resident #015.

In an interview, PSW #128 indicated that resident #016 had a history of inappropriate behaviours towards co-residents. The PSW considered the incident to be abuse by resident #016 towards resident #015.

At the time of this inspection, PSW #127 was no longer an employee of the home. Attempts to contact the PSW was unsuccessful.

In interviews, RN #113 and PSW #129 indicated that resident #016 had behavioural symptoms towards and identified group of co-residents. Resident #016 frequently entered specific resident rooms. They indicated that a wander guard strip was put across the rooms resident #016 frequented to prevent them from entering the room.

The resident was also monitored for their whereabouts every 15 minutes to observe their behavioural symptoms.

A record review of resident #016's clinical records indicated they were followed by an external consultant to manage the resident's behavioural symptoms towards co-residents. The external consultant assessed the resident on an identified date with recommendations to continue with interventions, monitor every 30 minutes for safety and medication recommendations.

A review of the physician's orders indicated that the resident was ordered medical interventions to decrease resident #016's behavioural symptoms after the CIS incident.

A review of the plan of care for resident #016 did not have documentation on new interventions after the two documented incidents on identified dates to prevent recurrence and manage the resident's inappropriate behaviours.

In interviews, the Administrator and NM #105 indicated that there were no new interventions put in place after identified dates of the incidences to prevent resident #016's behavioural symptoms.The NM and Administrator indicated that the staff continued to monitor resident #016 after the incidents. Therefore, the home failed to ensure that resident #015 was protected from abuse by resident #016.

(665)

3. Record review of CIS report on an identified date, indicated resident #004 went into resident #005's room and the housekeeper observed resident #005 push resident #004 and they fell to the ground. Resident #004 was assessed and it was noted that their identified body part had a deficit and resident #004 was transferred to the hospital. Resident #004 sustained an injury and underwent a medical procedure.

Record review of resident #004's progress notes on an identified date, indicated resident #004 was pushed by resident #005 and resident #004 presented with an identified deficit upon assessment an as a result was transferred to hospital.

In an interview housekeeper #128 verified they witnessed resident #005 push resident #004 on an identified date and resident #004 fell to the ground.

In an interview nurse manager #105 acknowledged resident #004 was pushed by resident #005.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident.
The scope of the issue was a level 1 as it was isolated related to the residents that were reviewed. The home had a level 4 history of on-going non-compliance with this section of the Act that included:
-Compliance Order issued 18-Sep-18 -(2018_644507_0015)
-Compliance Order issued 17-Aug-18- (2018_462600_0010)
-Compliance Order issued 20-Jul-18- (2018_751649_0011)
-Voluntary Plan of Corrective actions issued 29-Mar-17- (2017_641513_0006) (652)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 28, 2019(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:

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 14th day of May, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by NATALIE MOLIN (652) - (A1)

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 Service Area Office