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_0005 (A1)	033758-18, 005161-19, 005252-19, 007529-19	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

Amended by NATALIE MOLIN (652) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

An extension to the compliance date has been granted to Licensee. The new compliance 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.

Ministry of Health and Long-Term Care

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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 Complaint inspection.

This inspection was conducted on the following date(s): March 22, 25,26, 27, 28, and April 1, 2, 3, and 9, 10, 2019.

The following complaint inspections were conducted:

Log #005252-19 related to unexpected death

Log # 007529-19 related to unexpected death.

The following critical incident system (CIS) inspections were conducted concurrently with the complaint inspection:

Log #005161-19, CIS #2591-000005-19 related to unexpected death

Log #033758-18, CIS #2591000045-18 related to incident with injury/hospital transfer and significant change in status.

During the course of the inspection, the inspector(s) spoke with the director of care (DOC), nurse managers (NM), registered nursing staff, personal support workers (PSWs), physiotherapist (PT), registered dietitian (RD), rehabilitation nursing restorative and complainant .

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:

Falls Prevention
Nutrition and Hydration

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

- **2 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint through the Action-line on identified dates regarding care related to resident #001's identified incident resulting in death.

MOHLTC received a critical incident system (CIS) report on an identified date. This CIS indicated on an identified date and time resident #001 was served their meal by registered practical nurse (RPN) #104 and while resident #001 was consuming their meal, RPN #104 went to pour resident #001 a beverage and upon returning back to resident #001's table, RPN #104 noted resident #001 was unresponsive. Registered nurse (RN) #101 started cardiopulmonary resuscitation (CPR) and instructed RPN #104 to call a code blue. The fire department arrived and paramedics arrived at an identified time and continued with resuscitation procedures. The attending physician was notified. Resident #001 was declared vital signs absent at an identified time. The coroner and the police were on site

and resident #001's cause of death was verified.

During observations of where the incident occurred it had been identified that resident #001 was sitting in an identified location and a short distance away from where RPN #104 went to get a beverage for resident #001.

Record review of resident #001's written plan of care on an identified date indicated the resident tolerated an identified food texture. The goal was to maintain adequate level of functioning and there will be no episodes of an identified symptom. This plan of care also directed staff to implement an identified intervention.

Record review of resident #001's Physician's Order Review for an identified period verified resident #001's food texture for meals.

In an interview RPN #104 verified that for resident #001 the identified food resident #001 was eating at the time of the incident is classified as finger foods and the plan of care did not provide clear directions whether the identified intervention applied to finger foods.

DOC #109 acknowledged resident #001's plan of care should have provided clear directions.

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

MOHLTC received a corresponding CIS related to the complaint of resident #001. On an identified date before an identified meal service, resident #001 was assisted to an identified location by two staff members. One staff member left to attend to other residents while one remained at resident #001's side. When resident #001 completed their activities of daily living (ADL) task, they stood up and was not able to maintain their balance with one staff member and started to descend towards the floor. According to the personal support worker (PSW) #102, resident #001 was assisted down to the floor in a sitting position. PSW #102 called PSW #103 to assist with resident #001's care. PSWs #102 and #103 used an identified equipment to transfer resident #001 and resident #001 went to an identified meal service without any further events. The CIS indicated that several

hours later at an identified time, RPN #104 was advised that resident #001 was lowered to the ground prior to the identified meal service and that resident #001 did not fall. The CIS goes on to state that on an identified date and on an identified shift, the unit supervisor indicated that resident #001 complained of an identified symptom in an identified body part and upon assessment identified symptoms were verified by the registered staff. On an identified date, resident #001's friend reported that resident #001 had an identified symptom on an identified body part and that resident #001 had fallen two days prior. The Director of Care (DOC) #109 interviewed resident #001 on an identified date and resident #001 was able to recall and verified the events of the incident. Registered staff completed a head to toe assessment of resident #001 which revealed identified signs and symptoms.
The doctor was notified and an order was given to transfer resident #001 to the hospital for further assessment. Resident #001 returned to the nursing home with an identified diagnosis.

Record review of resident #001's progress notes indicated there was no documented evidence on an identified date, to indicate that resident #001 was assessed for a probable fall.

Record review of resident #001's progress notes on an identified date and time indicated they complained of identified symptoms, resident #001's identified body part was assessed by RPN #100 and was noted to have identified signs and symptoms. An identified medication was administered to resident #002 and a note was left in the doctor's communication book for follow-up.

Record review of resident #001's progress notes of an identified date indicated RN in charge #101 verified information provided by resident #001's friend #130 and conducted an assessment of the resident and confirmed symptoms identified in the CIS and health care records. Resident #001 was transferred to the hospital and received an identified diagnosis.

In an interview, resident #001's friend #130 indicated that resident #001 had informed them that they had fallen and was experiencing an identified symptom which had not been assessed and PSW #102 was one of the staff members whom resident #001 had mentioned transferred them.

In an interview PSW #102 indicated when resident #001 requested to go to an identified location, they transferred resident #001 to the location with the

assistance of PSW #103.
PSW #102 also indicated PSW #103 left and went to attend to other residents while they remained with resident #001 in the identified location; when resident #001 completed their ADL task they asked PSW #103 for assistance and resident #001 stood up to hold the hand bar when PSW #102 realized that resident #001 could not put themselves down PSW #103 came and assisted PSW #102 to lower resident #001 to the floor. They then got an identified equipment and transferred resident #001 and took them to an identified meal service. PSW #102 indicated resident #001 did not have any signs and symptoms and did not fall. PSW #102 indicated that they were aware that it was a near miss because they lowered resident #001 to the ground.

In an interview PSW #103 acknowledged that they transferred resident #001 without an identified equipment when they first transferred resident #001. PSW #103 indicated they held resident #001 one person on either side because resident #001 could perform an identified task. PSW #103 also indicated that they had left PSW #102 and resident #001. PSW #103 indicated they heard PSW #102 screaming for assistance and when they arrived resident #001 was sitting on the floor. PSW #102 told PSW #103 that resident #001 did not fall and both PSWs used an identified equipment at this time to transfer resident #001.PSW #102 and PSW #103 verified they did not get the registered staff to assess resident #001 prior to picking resident #001 of the floor.

In an interview RPN #104 acknowledged on an identified date, they did not document the information provided to them by PSW #102 and PSW #103 and did not consider resident #001's circumstances a near miss or a fall. RPN #104 also acknowledged that they should have documented the outcome of an identified assessment they completed for resident #001 on an identified date.

In an interview RPN #100 acknowledged they did not go back and reassess resident #001's symptoms on an identified body part on an identified date.

There is no documented evidence in resident 001's healthcare records to indicate that the registered staff on the other identified shifts assessed the status of resident #001's identified body part.

Nurse Manager #101 verified that the registered staff on identified shifts should have assessed and reassessed the status of resident #001's identified body part.

DOC #109 acknowledged the expectation is that a reassessment of resident #001's identified body part should have been completed by the registered staff on identified shifts and on an identified date when it had been identified that resident #001 experienced identified symptoms. DOC also acknowledged a fall risk assessment using the home's fall risk clinical tool should have been completed for resident #001 when there was a significant change in their health status.

3. MOHLTC received a complaint through the Action-line on identified dates regarding care related to resident #001's incident resulting in death.

MOHLTC received a critical incident system (CIS) report on an identified date. This CIS indicated on an identified date and time resident #001 was served their meals by the registered practical nurse (RPN) #104 and while resident #001 was consuming their meal, RPN #104 went to pour resident #001 a beverage and upon returning back to resident #001's table, RPN #104 noted resident #001 was unresponsive. A registered nurse (RN) #101 started cardiopulmonary resuscitation (CPR) and instructed RPN #104 to call a Code Blue. The fire department arrived and paramedics arrived at an identified time and continued with resuscitation procedures. The attending physician was notified. Resident #001 was declared vital signs absent at an identified time. The coroner and the police were on site and resident #001's cause of death was verified.

In an interview RPN #104 verified the location, shift and meal service when the identified incident occurred with resident #001. RPN #104 also provided a descriptor of the type of food resident #001 was eating at the time of the incident and indicated they had left resident #001 to get a beverage for resident #001. RPN #104 indicated upon returning to resident #001's table it was noted that resident #001 was unresponsive therefore RPN #104 yelled for help and RN #101 on the unit at the time responded to the scene and directed RPN #104 to initiate Code blue while RN #104 conducted CPR on resident #001 with the assistance of another RPN. RPN #104 verified they did not implement the identified intervention since it was finger foods and resident #001's care plan was not specific whether the identified intervention applied to finger foods. RPN #104 indicated what they would have done differently was to pull the food cart closer to resident #001 and implement the identified intervention at the time of the incident.

In an interview with resident #001's friend #130 indicated when they visited resident #001 in the nursing home they observed that resident #001 had identified signs and symptoms during meals. Friend #130 indicated they asked resident

#001 if the doctor was aware of the symptoms and resident #001 indicated the doctor was aware. Friend #130 also indicated when they go out with resident #001; resident #001 would chew only certain foods.They also indicated that they did not visit during snack time but resident #001 did complain that the home were was providing an identified texture.

In an interview rehabilitation restorative therapist (RRT) #123 indicated they had observed resident #001 had identified symptoms prior to this incident. RRT #123 also indicated they observed that there were times when resident #001 demonstrated identified symptoms while they were eating, drinking fluids and that the symptoms occurred often. RRT #123 also indicated there was no follow-up regarding resident #001's symptoms and they were not sure if resident #001 was referred to an identified specialist. RRT #123 verified that they had not communicated their observations of resident #001's symptoms to the team.

In an interview rehab nursing restorative therapist (RNRT) #122 indicated resident #001 had an identified deficit due to an identified diagnosis and was not at risk, however because of resident #001's limitation they recommended the identified intervention so resident #001 could have managed and that resident #001 required supervision and cuing and when resident #001 ate in an identified location prior to this incident they sat where they could be seen. RNRT #122 indicated the plan was still supervision and someone should have been looking and all meals should have been provided at the same time and that included the beverage. RNRT #122 indicated for pleasurable dining staff were to serve the identified food as it was, but ask the resident whether they wanted the intervention to be implemented. RNRT #122 indicated resident #001 ate in an identified location due to behavioural symptoms and is aware that resident #001 would talk and yelled while eating.

In an interview registered dietitian (RD) #124 indicated during resident #001's last annual dietary assessment they were on an identified diet texture as per RD #124's directive. RD #124 indicated that resident #001 had no identified difficulties, a minimal dietary deficit was identified but was able to tolerate food. RD #124 also indicated they were not aware of the rationale for the identified intervention as the plan of care did not come from them but was a restorative intervention.

In an interview nurse in charge (NIC) #101 verified that on an identified date, when the incident occurred, they were on the unit and responded to the incident

and when they arrived resident #001 was unresponsive. NIC #101 acknowledged resident #001's plan of care directed staff to provide supervision with set up help, implement the identified intervention for easy intake, move resident #001 close to the table and make sure utensils are close and all the meals served at the same time.

Resident #001 was at a prior risk for for an identified condition as was identified by resident #001's friend #130 and RRT #123, further to this, the RD #124 was unaware of the rationale for the interventions that restorative staff had put in place as well as observations made by RNRT #123 related to resident #001's possible risk for risk of an identified condition.

The licensee did not ensure that the different aspects of care collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other.

4. The licensee has failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan.

Resident #011 was added to this inspection as a result of the mandatory expansion of the resident sample.

Record review of resident #011's written plan of care on an identified date, indicated they were at risk for falls characterized by a history of fall and multiple risk factors related
to an identified deficit. This written plan of care directed staff to check every one hour to ensure resident #001's safety and to ensure they wore an identified protective garment due to resident #001's high risk for falls.

On an identified date, resident #011 was observed sitting in an identified location and PSW #129 acknowledged resident #011 was not wearing their protective garments. On this same date PSW #129 also acknowledged that they did not do the every one hour (Q1H) checks on resident #001.

On an identified date, resident #011 was observed attempting to get out of their chair and PSW #118 assisted to readjust resident #011 in their chair and confirmed resident #011 did not appear to be wearing their protective garment. On this same date RPN #127 also verified that resident #011 was not wearing their protective garment.

Record review of resident #011's progress notes and fall risk assessment for an identified period indicated they are at high risk for falls.

Record review of resident #011's Kardex Report indicated resident #011 was at risk for falls and staff was directed to ensure resident #011 wears the protective garment
and check resident every 1 hour to ensure safety.

Nurse Manager #113 acknowledged resident #011's Q1H safety checks was not completed and PSW #129 did not follow the plan of care.

5. MOHLTC received a complaint through the Action-line on identified dates regarding care related to resident #001’s identified incident resulting in death.

Record review of resident’s written plan of care on an identified date directed staff to implement an identified intervention.

In an interview RPN #104 verified they did not implement the identified intervention at the time of the incident.

NIC #101 acknowledged resident #001's plan of care directed staff to implement the identified interventions.

6. MOHLTC received a complaint through the Action-line on an identified date regarding care concerns related to resident #001's improper transfer causing an identified injury.

Record review of resident #001’s written plan of care on an identified date directed staff to use an identified equipment for transfers.

In an interview PSW #103 acknowledged that they transferred resident #001 without an identified equipment when they first transferred resident #001. PSW #103 indicated they held resident #001 one person on either side because resident #001 could perform an identified task.

DOC #109 acknowledged it was implied that PSWs #102 and #103 transferred resident #001 to their chair and they went for supper without first being assessed for falls by RPN #104.

The home failed to provide care to resident #001 as specified in the plan.

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

(A1)
The following order(s) have been amended: CO# 001,002

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee ensured that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Record review of resident #001's progress notes indicated there is no documented evidence on an identified date to indicate that resident #001 was assessed for a probable fall when PSW #102 had identified that they assisted resident #001 to the floor and that both PSW #102 and PSW #103 transferred the resident back to their chair and was taken to supper prior to the registered staff assessment of resident #001.

In an interview RPN #104 verified when PSW #102 informed them that they saved resident #001 from falling and resident #001 said they did not fall and it was not the PSW's fault because the PSW saved them, RPN #104 indicated they checked resident #001 from head to toe and did not see identified symptoms and the resident did not complain. RPN #104 indicated they realized they should have documented the outcome of resident #011's Head to Toe Assessment.

DOC #109 acknowledged that RPN #104 should have documented the outcome of the head to toe assessment. [s. 30. (2)]

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 licensee ensured that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, 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.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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_0005 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	033758-18, 005161-19, 005252-19, 007529-19 (A1)
Type of Inspection / Genre d'inspection :	Complaint
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

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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. (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
(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).

Order / Ordre :

The licensee must be compliant with O. Reg 79/10, s. 6 (4) (a).

Specifically, the licensee must ensure:

1.That registered staff on all shifts determine the status of resident's condition when it has been identified that the resident experienced signs and symptoms that may indicate a near miss or actual fall. Any assessments or reassessments related to this near miss or actual fall must be documented on each shift.

2. If a resident has not been identified at high risk for an identified condition but has been observed coughing while eating or drinking on several occasions; this observation must be documented and communicated to the Registered Dietitian and/or the interdisciplinary team to rule out any dietary risk to the resident.

Grounds / Motifs :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

MOHLTC received a corresponding CIS related to the complaint of resident #001. On an identified date before an identified meal service, resident #001 was assisted to an identified location by two staff members. One staff member left to attend to other residents while one remained at resident #001's side. When resident #001 completed their activities of daily living (ADL) task, they stood up and was not able to maintain their balance with one staff member and started to descend towards the floor. According to the personal support worker (PSW) #102, resident #001 was assisted down to the floor in a sitting position. PSW #102 called PSW #103 to assist with resident #001's care. PSWs #102 and #103 used an identified equipment to transfer resident #001 and resident #001 went to an identified meal service without any further events. The CIS indicated that several hours later at an identified time, RPN #104 was advised that resident #001 was lowered to the ground prior to the identified meal service and that resident #001 did not fall. The CIS goes on to state that on an identified date and on an identified shift, the unit supervisor indicated that resident #001 complained of an identified symptom in an identified body part and upon assessment identified symptoms were verified by the registered staff. On an identified date, resident #001's friend reported that resident #001 had an identified symptom on an identified body part and that resident #001 had fallen two days prior. The Director of Care (DOC) #109 interviewed resident #001 on an identified date and resident #001 was able to recall and verified the events of the incident. Registered staff completed a head to toe assessment of resident #001 which revealed identified signs and symptoms.
The doctor was notified and an order was given to transfer resident #001 to the hospital for further assessment. Resident #001 returned to the nursing home with an identified diagnosis.

Record review of resident #001's progress notes indicated there was no documented evidence on an identified date, to indicate that resident #001 was assessed for a probable fall.

Record review of resident #001's progress notes on an identified date and time indicated they complained of identified symptoms, resident #001's identified body part was assessed by RPN #100 and was noted to have identified signs and symptoms. An identified medication was administered to resident #002 and a note was left in the doctor's communication book for follow-up.

Record review of resident #001's progress notes of an identified date indicated RN in charge #101 verified information provided by resident #001's friend #130 and conducted an assessment of the resident and confirmed symptoms identified in the CIS and health care records. Resident #001 was transferred to the hospital and received an identified diagnosis.

In an interview, resident #001's friend #130 indicated that resident #001 had informed them that they had fallen and was experiencing an identified symptom which had not been assessed and PSW #102 was one of the staff members whom resident #001 had mentioned transferred them.

In an interview PSW #102 indicated when resident #001 requested to go to an identified location, they transferred resident #001 to the location with the assistance of PSW #103. PSW #102 also indicated PSW #103 left and went to attend to other residents while they remained with resident #001 in the identified location; when resident #001 completed their ADL task they asked PSW #103 for assistance and resident #001 stood up to hold the hand bar when PSW #102 realized that resident #001 could not put themselves down PSW #103 came and assisted PSW #102 to lower resident #001 to the floor. They then got an identified equipment and transferred resident #001 and took them to an identified meal service. PSW #102 indicated resident #001 did not have any signs and symptoms and did not fall. PSW #102 indicated that they were aware that it was a near miss because they lowered resident #001 to the ground.

In an interview PSW #103 acknowledged that they transferred resident #001 without an identified equipment when they first transferred resident #001. PSW #103 indicated they held resident #001 one person on either side because resident #001 could perform an identified task. PSW #103 also indicated that they had left PSW #102 and resident #001. PSW #103 indicated they heard PSW #102 screaming for assistance and when they arrived resident #001 was sitting on the floor. PSW #102 told PSW #103 that resident #001 did not fall and both PSWs used an identified equipment at this time to transfer resident #001.PSW #102 and PSW #103 verified they did not get the registered staff to assess resident #001 prior to picking resident #001 of the floor.

In an interview RPN #104 acknowledged on an identified date, they did not document the information provided to them by PSW #102 and PSW #103 and did not consider

resident #001’s circumstances a near miss or a fall. RPN #104 also acknowledged that they should have documented the outcome of an identified assessment they completed for resident #001 on an identified date.

In an interview RPN #100 acknowledged they did not go back and reassess resident #001’s symptoms on an identified body part on an identified date.

There is no documented evidence in resident 001’s healthcare records to indicate that the registered staff on the other identified shifts assessed the status of resident #001’s Identified body part.

Nurse Manager #101 verified that the registered staff on identified shifts should have assessed and reassessed the status of resident #001’s identified body part.

DOC #109 acknowledged the expectation is that a reassessment of resident #001's identified body part should have been completed by the registered staff on identified shifts and on an identified date when it had been identified that resident #001 experienced identified symptoms. DOC also acknowledged a fall risk assessment using the home’s fall risk clinical tool should have been completed for resident #001 when there was a significant change in their health status.

(652)

2. MOHLTC received a complaint through the Action-line on identified dates regarding care related to resident #001’s incident resulting in death.

MOHLTC received a critical incident system (CIS) report on an identified date. This CIS indicated on an identified date and time resident #001 was served their meals by the registered practical nurse (RPN) #104 and while resident #001 was consuming their meal, RPN #104 went to pour resident #001 a beverage and upon returning back to resident #001’s table, RPN #104 noted resident #001 was unresponsive. A registered nurse (RN) #101 started cardiopulmonary resuscitation (CPR) and instructed RPN #104 to call a Code Blue. The fire department arrived and paramedics arrived at an identified time and continued with resuscitation procedures. The attending physician was notified. Resident #001 was declared vital signs absent at an identified time. The coroner and the police were on site and resident #001’s cause of death was verified.

In an interview RPN #104 verified the location, shift and meal service when the identified incident occurred with resident #001. RPN #104 also provided a descriptor of the type of food resident #001 was eating at the time of the incident and indicated they had left resident #001 to get a beverage for resident #001. RPN #104 indicated upon returning to resident #001's table it was noted that resident #001 was unresponsive therefore RPN #104 yelled for help and RN #101 on the unit at the time responded to the scene and directed RPN #104 to initiate Code Blue while RN #104 conducted CPR on resident #001 with the assistance of another RPN. RPN #104 verified they did not implement the identified intervention since it was finger foods and resident #001's care plan was not specific whether the identified intervention applied to finger foods. RPN #104 indicated what they would have done differently was to pull the food cart closer to resident #001 and implement the identified intervention at the time of the incident.

In an interview with resident #001's friend #130 indicated when they visited resident #001 in the nursing home they observed that resident #001 had identified signs and symptoms during meals. Friend #130 indicated they asked resident #001 if the doctor was aware of the symptoms and resident #001 indicated the doctor was aware. Friend #130 also indicated when they go out with resident #001; resident #001 would chew only certain foods.They also indicated that they did not visit during snack time but resident #001 did complain that the home were was providing an identified texture.

In an interview rehabilitation restorative therapist (RRT) #123 indicated they had observed resident #001 had identified symptoms prior to this incident. RRT #123 also indicated they observed that there were times when resident #001 demonstrated identified symptoms while they were eating, drinking fluids and that the symptoms occurred often. RRT #123 also indicated there was no follow-up regarding resident #001's symptoms and they were not sure if resident #001 was referred to an identified specialist. RRT #123 verified that they had not communicated their observations of resident #001's symptoms to the team.

In an interview rehab nursing restorative therapist (RNRT) #122 indicated resident #001 had an identified deficit due to an identified diagnosis and was not at risk, however because of resident #001's limitation they recommended the identified intervention so resident #001 could have managed and that resident #001 required supervision and cuing and when resident #001 ate in an identified location prior to

this incident they sat where they could be seen. RNRT #122 indicated the plan was still supervision and someone should have been looking and all meals should have been provided at the same time and that included the beverage. RNRT #122 indicated for pleasurable dining staff were to serve the identified food as it was, but ask the resident whether they wanted the intervention to be implemented. RNRT #122 indicated resident #001 ate in an identified location due to behavioural symptoms and is aware that resident #001 would talk and yelled while eating.

In an interview registered dietitian (RD) #124 indicated during resident #001’s last annual dietary assessment they were on an identified diet texture as per RD #124's directive. RD #124 indicated that resident #001 had no identified difficulties, a minimal dietary deficit was identified but was able to tolerate food. RD #124 also indicated they were not aware of the rationale for the identified intervention as the plan of care did not come from them but was a restorative intervention.

In an interview nurse in charge (NIC) #101 verified that on an identified date, when the incident occurred, they were on the unit and responded to the incident and when they arrived resident #001 was unresponsive. NIC #101 acknowledged resident #001's plan of care directed staff to provide supervision with set up help, implement the identified intervention for easy intake, move resident #001 close to the table and make sure utensils are close and all the meals served at the same time.

Resident #001 was at a prior risk for an identified condition as was identified by resident #001's friend #130 and RRT #123, further to this, the RD #124 was unaware of the rationale for the interventions that restorative staff had put in place as well as observations made by RNRT #123 related to resident #001's possible risk for an identified condition.

The licensee did not ensure that the different aspects of care collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other.
The licensee did not ensure that the different aspects of care collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other.

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:
-Voluntary plan of correction (VPC) issued 31-Jan-19, (2019_644507_0001) (652)

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

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with O. Reg 79/10, s. 6 (7)

Specifically, the licensee must ensure:

1. (a) Staff is transferring residents with the recommended mechanical devices at all times.

(b) Resident's are wearing their protective garment as recommended to reduce the impact of falls.

(c) Resident's interventions are implemented as recommended.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan.

Resident #011 was added to this inspection as a result of the mandatory expansion of the resident sample.

Record review of resident #011's written plan of care on an identified date, indicated they were at risk for falls characterized by a history of fall and multiple risk factors related to an identified deficit. This written plan of care directed staff to check every one hour to ensure resident #001’s safety and to ensure they wore and identified protective garment due to resident #001’s high risk for falls.

On an identified date, resident #011 was observed sitting in an identified location and PSW #129 acknowledged resident #011 was not wearing their protective garments. On this same date PSW #129 also acknowledged that they did not do the every one hour (Q1H) checks on resident #001.

On an identified date, resident #011 was observed attempting to get out of their chair and PSW #118 assisted to readjust resident #011 in their chair and confirmed resident #011 did not appear to be wearing their protective garment. On this same date RPN #127 also verified that resident #011 was not wearing their protective garment.

Record review of resident #011's progress notes and fall risk assessment for an identified period indicated they are at high risk for falls.

Record review of resident #011's Kardex Report indicated resident #011 was at risk for falls and staff was directed to ensure resident #011 wears the protective garment and check resident every 1 hour to ensure safety.

Nurse Manager #113 acknowledged resident #011's Q1H safety checks was not completed and PSW #129 did not follow the plan of care. (652)

2. MOHLTC received a complaint through the Action-line on identified dates regarding care related to resident #001's identified incident resulting in death.

Record review of resident's written plan of care on an identified date directed staff to implement an identified intervention.

In an interview RPN #104 verified they did not implement the identified intervention at the time of the incident.

NIC #101 acknowledged resident #001's plan of care directed staff to implement the identified interventions. (652)

3. 6. MOHLTC received a complaint through the Action-line on an identified date regarding care concerns related to resident #001's improper transfer causing an identified injury.

Record review of resident #001's written plan of care on an identified date directed staff to use an identified equipment for transfers.

In an interview PSW #103 acknowledged that they transferred resident #001 without an identified equipment when they first transferred resident #001. PSW #103 indicated they held resident #001 one person on either side because resident #001 could perform an identified task.

DOC #109 acknowledged it was implied that PSWs #102 and #103 transferred resident #001 to their chair and they went for supper without first being assessed for falls by RPN #104.

The home failed to provide care to resident #001 as specified in the plan.

The home failed to provide care to resident #001 as specified in the plan.
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:
-Voluntary plan of correction (VPC) issued 4-Dec-2017, (2017_652625_0020)
-Voluntary plan of correction (VPC) issued 17-Aug-2018 (2018_644507_0013)
(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:

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)

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