Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 22, 2020	2019_631210_0028	019067-19	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

SLAVICA VUCKO (210)

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): December 17, 18, 20, 23, 24 and 27, 2019.

The following Complaint intake was inspected:
- Log #019067-19 related to continence care management and prevention of alleged abuse and neglect.

This inspection was conducted concurrently with Critical Incident System (CIS) report # 2591-000036-19 (intake #019664-19).

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Personal Support Workers (PSWs), Supply Company Representative, and residents.

During the course of the inspection the inspector observed staff to resident interactions, the provision of care, reviewed residents' health records, staff training records, home's investigation notes, and any relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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 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 has not been effective.

A complaint was submitted to the Ministry of Long term Care (MLTC) on a specified date, by resident #001 in regards to their specific health condition and a device in place to manage the condition. They indicated they have a specific device in place that is malfunctioning on a daily basis and the home does not fix it quickly enough. They have accidents all the time and they need help.

A review of resident #001’s clinical record indicated the resident was admitted in the home on a specified date, with a specific device in place for a specific health condition. The resident had the device for a significant time period.

Interview with resident #001 indicated they have the device in place and it has to be maintained in a particular way every day. During the interview the resident indicated that they are able to maintain the device to a certain degree. They further indicated that if they do not remove the device the registered staff will not come quickly enough to apply a new device. They stated that they went to a specific hospital for assessment by a specialist several times in the last few months, and they hoped that they would see another healthcare specialist who has expertize in the specific device and would assess the healthcare issue related to the need of the device.

A review of resident #001's written plan of care indicated the resident required one person limited assistance for personal care and one person standby assist if they ask for assistance, otherwise they can perform the personal care on their own. The resident is a two person approach in all aspects of personal care due to responsive behaviour. Staff to let them initiate and complete the sequence of the tasks. Registered staff are to provide care of the specific device every two hours, and as needed. The resident has been encouraged and instructed by staff to leave the device on and the device can be assessed, however resident would remove the device before it is assessed by the nurse. A review of the electronic Treatment Administration Record (eTAR) indicated that it was initiated on a specific date, the registered staff to check the device for proper functioning every two hours and assist the resident if help is required. Registered staff to document when the device requires changing.

A review of resident #001's clinical record indicated that on a specified date, the resident was assessed at a specific hospital for their health condition and a report was sent to the home indicating that the doctor would try to find a specialist with expertize in the specific device to connect with the resident. The hospital report further indicated that the resident's family physician could find the specific specialist as well.

Interview with RN #100 indicated that they were not able to find evidence that the home arranged the specific specialist to assess resident #001's device and condition after they visited the hospital. RN #100 and DOC were not able to explain if the home has a protocol in place for referral to a specialist with expertize in the specific device.

Interview with RN #111 indicated that resident #001 was assessed at a clinic in the community by a specialist for the device several months ago on their initiative but was not able to find the report in the resident's chart. RN #111 recalled seeing the report that stated the resident did not need to go to the clinic anymore.

During the course of the inspection resident #001 approached the inspector several times indicating that the specific device was changed several times a day due to malfunctioning. They further indicated that they would remove the device before the registered staff was given opportunity to assess it for malfunctioning.

Review of the progress notes indicated that in the period of one month the device was changed on average every day. Approximately half of the changes happened because the resident removed the device before the registered staff had the opportunity to assess it for malfunctioning.

Review of the written plan of care and interviews with RN #100, RPN #103 and DOC indicated that when resident #001 started complaining about the management of the device, and the frequent changes of the device, there was no re-assessment in place about the efficacy of the device. [s. 6. (10) (c)]

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 resident is 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 has not been effective, to be implemented voluntarily.

Issued on this 23rd day of January, 2020

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

Original report signed by the inspector.