Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 17, 2014	2014_219211_0001	T-316-13	Complaint

Licensee/Titulaire de permis

601091 ONTARIO LIMITED
429 WALMER ROAD, TORONTO, ON, M5P-2X9

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

JOELLE TAILLEFER (211)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 6, 8, 9, 10, 2014

During the course of the inspection, the inspector(s) spoke with administrator, director of nursing, nurse manager, assistant nurse manager, registered physiotherapist, registered staff, personal support workers, residents and residents' families.

During the course of the inspection, the inspector(s) observed provision of care, reviewed residents' records, reviewed home's skin and wound care policy and program.

The following Inspection Protocols were used during this inspection:

Personal Support Services
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. (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).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to resident #1 and resident #2 as follow;
On January 6, 2014, clinical record review and staff interview confirmed that resident #2's plan of care did not provide clear direction to staff in relation to resident's need to be transferred into bed for a rest period. [s. 6. (1) (c)]

2. Clinical records review from identified dates revealed and staff interview confirmed resident #1's plan of care did not indicate that the resident should be repositioned with assistance every two hours while in bed. [s. 6. (1) (c)]

3. The licensee failed to ensure that resident's repositioning has been documented in the plan of care.
Clinical records review and staff interview indicated that staff did not document resident # 1's repositioning or refusal to be repositioned every two hours when in bed or when sitting in the wheelchair on identified dates. [s. 6. (9) 1.]

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Issued on this 17th day of January, 2014

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

Joelle Taillefer RN, BScN