**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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## Public Copy/Copie 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 |
| --- | --- | --- | --- |
| Aug 16, 2019 | 2019_654618_0027 | 004454-18, 007245-18, 009264-18, 016032-18, 003143-19 | Critical Incident System |

**Licensee/Titulaire de permis**

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

**Long-Term Care Home/Foyer de soins de longue durée**

Cedarvale Lodge Retirement and Care Community
121 Morton Avenue Keswick ON L4P 2M5

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

CECILIA FULTON (618)

## 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): August 12, 13, 14, 15, 2019.**

**The following intake logs were inspected during this inspection:**
**Log #007245-18, CIS #2769-000005-18, Log #003143-19, CIS #2769-000005-19, and Log #004454-18, CIS #2769-000002-18 related to responsive behaviours and prevention of abuse.**
**Log #016032-18, CIS #2769-000009-18, and Log #009264-18, CIS #2769-000008-18 related to falls prevention**

**During the course of the inspection, the inspector(s) spoke with the Assistant Director of Care (ADOC), Registered Staff (RN/RPN), Physiotherapist (PT) and Personal Support Workers (PSW)**

**During the course of the inspection, the inspector conducted record review, observed staff to resident interactions, and observed resident equipment.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**

**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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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).**

**Findings/Faits saillants :**

1. The Licensee has failed to ensure that there was a written plan of care for resident #006 which set out the planned care for the resident, including identifying the goals the care was intended to provide and which provided clear direction to staff and others who provided direct care to resident #006.

This inspection was initiated in response to a fall.  Review of the Critical Incident System (CIS) report regarding this incident identified that the resident had been assessed for identified seating equipment.

The identified seating equipment had been added to the residents plan of care based on an Occupational therapist (OT) assessment conducted in 2018.

Review of resident #006's clinical records, including all physiotherapist notes, progress notes, kardex and plan of care did not include any mention of this intervention.

Observation of the resident identified the presence of the identified seating equipment, and the PT confirmed that the equipment was what had been ordered and they identified the goal of the equipment.

Interview with RN #101, confirmed that the use of this equipment should be included in the resident's plan of care, and RN #101 was not sure of the purpose of this intervention.

Interview with PSW #109, identified that they were not certain of any details regarding the use of this equipment.  PSW #109 stated that they were uncertain if it was included in the resident's written plan of care, or if it should be.

Interview with the ADOC confirmed that the use of the identified seating equipment, including the goals should be included in the residents written plan of care and that it was not. [s. 6. (1) (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 there is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.***

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**Issued on this 16th day of August, 2019**

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

**Original report signed by the inspector.**