Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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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
Sep 6, 2019	2019_685648_0016	002162-19, 015282-19	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

JOVAIRIA AWAN (648)

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 21, and August 26, 2019

The following Critical Incident System reports were inspected:
Log #015282-19, related to a resident to resident altercation
Log #002161-19, related to resident to resident altercation

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse (RPN), and Personal Support Workers (PSW)

The following Inspection Protocols were used during this inspection:
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. (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 failed to ensure that care set out in the plan of care is provided to the resident as specified in the plan.

The home submitted a Critical Incident System report to the Ministry of Long Term Care (MLTC) on an identified date indicating resident #003 and #004 had an interaction. The CIS further indicated resident #003 had an identified intervention in place on, and the staff did not provide the intervention at the time of incident between resident #003 and #004.

Review of residents #003's clinical records, identified an intervention per the recommendations made by the interdisciplinary team. Review of resident #003's clinical records from an identified date leading up to the incident, identified an ongoing history of responsive behaviours expressed by resident #003 towards co-residents in the home.

Resident #003's written plan of care in place at the time of the incident directed staff to have in place the identified intervention to respond to resident #003 behaviours when awake. the resident when they were awake.

An interview with PSW #104 identified they heard a verbal altercation in resident #004's room on the identified date and time of the reported incident. PSW #104 stated they proceeded to the room and witnessed resident an alteracation between the two residents. PSW #104 confirmed resident #003 did not have the identified intervention in place at the time of incident.

Interview with RN #101 confirmed PSW #104's report of the incident. RN #101 identified PSW #106 was assigned to provide the identified intervention at the time to resident #003. RN #101 confirmed PSW #106 had left the home area without reporting to staff. RN #101 confirmed resident was not provided the identified interventionas directed in their plan of care.

Interviews with PSW #100, 102, 104, RN#101, and RPN #103 identified the ordered intervention should have been in place at all times and when staff were not able to provide the intervention they were to assign to another colleague.

Staff interviews with PSW #104 and RN #101, resident #003's record review, and the CIS report as submitted to the MLTC were reviewed with the homes DOC. The DOC acknowledged the identified intervention in place for resident #003 had not been provided on the identified date and time resulting in a resident to resident incident. [s. 6. (7)]

Issued on this 24th day of September, 2019

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

Original report signed by the inspector.