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

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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
Dec 3, 2019	2019_832604_0029	019806-19	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

SHIHANA RUMZI (604), MOSES NEELAM (762)

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): November 18, 19, 20, 21, 22, 25, 26, 27, and 28, 2019.

During the inspection intake log #019806-19, related to abuse was inspected.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Dietitian (RD), Registered Nurse (RN), Charge Registered Nurse (CRN), Personal Support Worker (PSW), Recreation Aide (RA), and Substitute Decision Makers (SDM).

During the course of the inspection, the inspector made observations of staff and resident interactions, provision of care, conducted reviews of health records, home's critical incident logs, staff training records, and relevant home policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **2 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. (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 :

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

On an identified date, the home called the Ministry of Long-Term Care (MLTC) After Hours Pager and submitted a Critical Incident System (CIS) report, to the Director which reported staff to resident abuse had occurred. The CIS report stated, resident #003 told Registered Practical Nurse (RPN) #103 that Personal Support Worker (PSW) #106 had abused them.

During an interview with resident #003, the resident alleged resident #004 presented with an identified responsive behaviour towards them. The resident was unable to recall the date this incident had occurred. The resident stated their family provided them with an identified personal device which they carry and will utilize if resident #004 is close to them.

A review of resident #003's plan of care was reviewed and the plan of care did not indicate the resident had an identified personal device and what it was utilized for.

In separate interviews with RPN #103 and #105, and PSW #107, the staff indicated they would refer to the residents plan of care to gather information related to the residents care needs. The staff indicated resident #003's family provided the resident with an identified personal device and the resident would utilize it when needed. The staff reviewed the above plan of care and confirmed that the plan of care did not give clear direction as to resident #003 carrying an identified personal device and what they utilized it for. The staff stated not all staff work with resident #003 consistently and would not know the resident had a identified personal device as it is not on the plan of care.

During the interview with DOC #100, the DOC reviewed resident #003's plan of care as indicated above and acknowledged that the plan of care did not give all staff clear direction as to the residents use of an identified personal device.

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 plan of care sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

The licensee has failed to ensure strategies where developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

On an identified date, the home called the Ministry of Long-Term Care (MLTC) After Hours Pager and submitted a Critical Incident System (CIS) report, to the Director which reported staff to resident abuse had occurred. The CIS report stated, resident #003 told Registered Practical Nurse (RPN) #103 that Personal Support Worker (PSW) #106 had abused them.

During an interview with resident #003, the resident alleged resident #004 presented with an identified responsive behaviour towards them. The resident was unable to recall the date this incident had occurred. The resident stated their family provided them with an identified personal device which they carry and will utilize if resident #004 is close to them.

A review of resident #004's progress notes where reviewed for an identified period of time and during the review it was noted resident #004 presented with multiple identified responsive behaviours.

A review of resident #004's plans of care with identified dates where reviewed and did not consist of an identified responsive behaviour focus or interventions.

In separate interviews RPN #103 and #105, and PSW #107 indicated the staff refer to the resident's plan of care to gather information related to resident care needs and responsive behaviours. The RPN's and PSW staff indicated resident #004 presented with an identified responsive behaviour and reviewed the residents plans of care. The RPN's and PSW staff acknowledged there where no strategies developed and implemented to respond to resident #004's demonstrated responsive behaviours.

In an interview with DOC #100 they indicated resident #004 reviewed the above plans of care and acknowledged there where no strategies developed and implemented to respond to resident #004's demonstrated responsive behaviours.

Issued on this 3rd day of December, 2019

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

Original report signed by the inspector.