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

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
Dec 19, 2019	2019_832604_0028	020588-19, 021884-19	Complaint

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

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The purpose of this inspection was to conduct a Complaint 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 the following intakes where inspected:
-Intake log related to resident care not provided
-Intake log related to responsive behavior and alleged abuse

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), Nurse Practitioner (NP), 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:
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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).

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 :

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The Ministry of Long-Term Care (MLTC) ACTIONline received a complaint related to resident #001 being abused by resident #002.

During an interview complainant #102 confirmed the above complaint and indicated the home had put in place an identified intervention for resident #001's safety. The complainant further indicated they had spoke to the Director of Care (DOC) #100 related to the intervention not being in place.

A review of resident #001's current plan of care included the above identified safety intervention.

An observation was carried out and it was noted that the intervention was not in place as indicated in resident #001's plan of care.

An interview and observation with Charge Registered Nurse (CRN) #101, acknowledged the intervention for resident #001's safety as indicated in their plan of care was not in place.

2. The MLTC ACTIONline received a complaint indicating they had concerns related to resident #006's care which included the management of two illness which was not addressed in a timely-manner, management of identified responsive behaviours once

resident returned from assessment, and short staffing.

During an interview complainant #110 confirmed the above complaints and stated during an identified time resident #006 was sent for assessment and returned to the home and the responsive behavior was not managed. The complainant further stated resident # 006 was involved in an altercation with resident #007.

A review of resident #006's plan of care consisted of a focus and intervention related to the residents identified responsive behaviours which was to be monitored.

A review of resident #006's identified monitoring sheets was carried out for an identified time period and the inspector noted on identified dates monitoring was not completed as indicated in the plan of care.

An interview the DOC #100 reviewed the monitoring sheets and acknowledged the plan of care was not provided to resident #006 as specified in the plan.

3. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the care set out in the plan was not effective.

The MLTC ACTIONline received a complaint indicating they had concerns related to resident #006's care which included the management of two illness which was not addressed in a timely-manner, management of identified responsive behaviours once resident returned from assessment, and short staffing.

During an interview complainant #110 confirmed the above complaints and stated during an identified time resident #006 was sent for assessment and returned to the home and stated that the responsive behavior was not managed. The complainant further stated resident # 006 was involved in an altercation with resident #007.

A review of resident #006's progress notes indicated the resident presented with multiple responsive behaviours on an identified shift. A progress note from a specified date indicated that resident #006 had an altercation with resident #007.

A review of resident #006's plan of care consisted of a focus and intervention related to the residents responsive behaviours, yet the resident kept presenting with the same responsive behaviours. There was no evidence to show that the plan of care was

reviewed and revised when the planed interventions were not effective.

During separate interviews the Nurse Practitioner (NP) #109 and DOC #100, reviewed the plans of care and progress notes and acknowledged resident #006 continued to present with responsive behaviors on an identified shift and the plan of care was not revised when the care set out in the plan was not been effective.

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 care set out in the plan of care was provided to the resident as specified in the plan,
-the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the care set out in the plan was not effective,, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone which resulted in harm or risk of harm has occurred shall immediately report the suspicion to the Director.

The home submitted an identified Critical Incident System (CIS) report on the MLTC Director indicating resident to resident abuse had occurred and the CIS report was submitted one day later after the abuse had occurred.

The sample size was expanded

A second identified CIS report was submitted two days later to the MLTC Director indicating resident to resident abuse had occurred.

An interview was carried out with the DOC who acknowledged the above two CIS reports related to resident to resident physical abuse was submitted late to the MLTC Director.

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 a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm has occurred shall immediately report the suspicion to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

The MLTC ACTIONline received a complaint indicating they had concerns related to resident #006's care which included the management of two illness which was not addressed in a timely-manner, management of responsive behaviours once resident returned from assessment, and short staffing.

During an interview complainant #110 confirmed the above complaints and stated during an identified time resident #006 was sent for assessment and returned to the home and responsive behavior was not managed. The complainant further stated resident # 006 was involved in an altercation with resident #007.

A review of the residents progress notes for an identified time period did not include any reference to altered skin integrity. The progress notes indicated resident #006 had was transferred to hospital on an identified date related to an alteration in skin integrity and the resident returned to the home the same day.

A review of the PCC Assessment tab did not show evidence of a skin or head to toe assessment was completed when resident #006 returned from hospital.

In separate interviews with Registered nurse (RN) #104 and DOC #100 acknowledged a skin assessment was not completed for resident #006 upon the return from the hospital.

Issued on this 19th day of December, 2019

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

Original report signed by the inspector.