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

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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 17, 2018	2018_644507_0013	008182-18, 010671-18, 011337-18	Complaint

Licensee/Titulaire de permis

Cedarvale Terrace LTC Inc. as general partner of Cedarvale Terrace LTC Limited Partnership
c/o All Seniors Care Living Centres 175 Bloor Street East, Suite 601 TORONTO ON M4W 3R8

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

STELLA NG (507)

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): May 31, June 1, 4-7, 11-12, 25 & 28, 2018.

The following complaints were inspected during this inspection:
 # 008182-18 related to alleged neglect, nutrition and hydration and plan of care, and
 # 011337-18 related to plan of care.

The following critical incident report was inspected concurrently with the complaint inspection:
#010671-18 regards to CIS #2591-000024-18 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Nurse Manager (NM), Associate Nurse Manager (ANM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Nursing Assistant (NA), Nursing Restorative Therapist (NRT), Registered Dietitian (RD), Food Service Manager (FSM), Housekeeper and Substitute Decision-Maker (SDM).

The inspectors conducted observations of staff and resident interactions, provision of care, dining and snack services, record review of resident and home records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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	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. (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 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 Health and Long Term Care (MOHLTC) received a complaint from resident #001's substitute decision-maker (SDM) in regards to the care provided to resident #001.

In an interview, resident #001's SDM stated that resident #001 was placed on a specific intervention on an identified date due to an incident that occurred the day before. Five days later when visiting the resident, resident #001's SDM noticed the above mentioned intervention was not in place.

Record review of the progress notes for resident #001 indicated that the resident was placed on a specific intervention on an identified date due to an incident that occurred the day before, as confirmed by interviews with staff #120 and #121.

In an interview, staff #120 stated that all staff assigned to provide the above mentioned specific intervention for resident #001 received instructions, shift report and the care plan for the resident prior to beginning the shift. In addition, all staff received a copy of the instructions.

In an interview, staff #121 stated that resident #001's SDM lodged a complaint in regards to the above mentioned intervention for resident #001 on an identified date. Record review of the home's investigation notes and interview with staff #121 indicated that staff #119 was assigned to provide the specific intervention to resident #001 on the above mentioned identified date for an identified period of time. Upon arriving at the home on the same day during the time the specific intervention was scheduled to be in place, resident #001's SDM noticed the specific intervention was not in place.

In an interview, staff #119 stated that on the above identified date, staff #119 was assigned to provide the specific intervention to resident #001 for a specific period. PSW #119 stated the specific intervention was not provided to resident #001 for a period of time.

In an interview, staff #121 stated that during the interview with staff #119, staff #119 indicated that on the above mentioned identified date, the specific intervention was not provided to resident #001 as instructed. Staff #121 acknowledged staff #119 did not provide the specific intervention to resident #001 on the above mentioned identified date

as indicated in the resident's plan of care. [s. 6. (7)]

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 is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident’s substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident was promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who were to be so notified.

A complaint was received on an identified date regarding resident #001's SDM was not notified of a serious incident immediately.

In an interview, resident #001’s SDM stated that on an identified date at an identified approximate time, resident #001’s SDM received a call from the emergency medical services (EMS) that resident #001 was transferred to the hospital because of an incident which occurred earlier. Resident #001’s SDM further stated a staff member from the home called at approximately two hours later informing the SDM that resident #001 was found at approximately five hours earlier and was sent to the hospital for further assessment.

Record review of the identified Critical Incident System (CIS) report and resident #001’s progress notes indicated that on the above mentioned identified date, at an identified approximate time, resident #001 was found lying in the room and was sent to the hospital for further assessment, and this was confirmed through an interview with staff #107.

In an interview, staff #107 stated that after resident #001 was taken to the hospital by EMS, staff #107 was busy in caring for other residents and did not call resident #001’s SDM immediately. Staff #107 also stated that resident #001’s SDM was notified of the incident and the transfer to the hospital at approximately five hours after the incident. Staff #107 stated resident #001’s SDM should be informed promptly of the incident and the transfer to the hospital.

In an interview, staff #143 acknowledged resident #001's SDM was not notified promptly after the incident on the above mentioned identified date. [s. 107. (5)]

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Issued on this 17th day of August, 2018

[redacted]

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

Original report signed by the inspector.