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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
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Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 16, 2014	2014_274535_0004	T-315-14	Complaint

Licensee/Titulaire de permis

601091 ONTARIO LIMITED
429 WALMER ROAD, TORONTO, ON, M5P-2X9

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

VERON ASH (535)

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): March 13, 14, 2014.

During the course of the inspection, the inspector(s) spoke with personal support workers (PSW), registered staff, unit supervisor, day nurse manager, associate director of care (ADOC), environmental service manager, director of nursing (DON), administrator, and the resident.

During the course of the inspection, the inspector(s) observed shower rooms on the third and fourth floors, conducted interviews, reviewed policy to promote zero tolerance of abuse and neglect, resident health records, staff training records, and home report of investigation and report of incident.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

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 O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident # 001 is showered, at a minimum, twice a week.

Resident # 001 care plan indicated a shower given twice weekly, on Tuesdays by the bath team, and on Saturdays by the assigned PSW. Record review and staff interviews confirmed that the resident is particular about how and by whom the shower is provided. The resident prefers to have a shower with towels spread on the floor to stand on, and to perform the wash slowly which increases the time it takes to complete the shower. The staff providing the shower must be patient and remain with the resident to offer support as needed.

On March 14, 2014, staff interview and health record review confirmed that the resident was not showered on the scheduled Tuesday and Saturday for periods ranging from one week to five consecutive weeks from January to March 2014. A review of the record also indicated that the resident has developed redness or a rash in the groin; however he/she is refusing to allow staff to complete an assessment, but continues to apply naturopathic cream to the affected area.

The resident brought the concern forward to the associate director of care and the unit supervisor, however the plan of care was not discussed or revised by the staff. The inspector informed the director of nursing and administrator who were both unaware that the resident had missed consecutive weeks of scheduled showers. The director of nursing then met with the resident and the associate director of care to review and revise the plan of care to ensure that the resident receives the scheduled showers twice weekly. [s. 33. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 :

1. The licensee failed to ensure that the written plan of care for resident # 001 sets out clear directions to staff and others who provide direct care to the resident.

Health records review indicated and staff interview confirmed that resident # 001 has been refusing the scheduled showers twice weekly. The resident has particular requests for how and by whom is to be provided the shower, however the plan of care did not include the particular instructions for staff who provide direct care. The associate director of care confirmed these specific requests related to the resident's shower since she provides the resident with a shower when possible. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

Resident # 001 prefers to have the shower with towels spread on the floor to stand on, and with staff who are patient and able to provide support only as needed. The resident experienced a stroke causing severe left-sided weakness of the arm and leg. Therefore, the resident performs the wash slowly which increases the time it takes to complete the shower, and also, the resident prefers to complete the shower in a specific manner. This information is not included in the resident's plan of care. An interview with the resident confirmed that this lack of knowledge is often a source of frustration for both the resident and the staff attempting to provide the shower. [s. 6. (2)]

3. The licensee failed to ensure that resident # 001 is reassessed and the plan of care reviewed and revised when care set out in the plan has not been effective.

Health records revealed and staff interviews confirmed that the resident's refusal to be showered and the reasons for refusing were not discussed, and the resident's plan of care was not revised by members of the staff even after the resident brought the concerns forward to the associate director of care and the unit supervisor. [s. 6. (10) (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 residents' plan of care sets out clear directions to staff and others who provide direct care, includes an assessment of the residents needs and preferences, is reviewed and revised if the plan has not been effective, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the shower rooms are kept clean and sanitary.

On March 13, 2014, the inspector observed and resident interview confirmed that the shower rooms on the second and third floor of the home had soap residue build up and mold growth on contact surfaces including the areas around the facets, between the tiles on the floors, including corners and edges.

The environmental services manager and the administrator were made aware of the situation and the environmental service manager made arrangements to have the shower rooms deep clean as soon as possible.

On March 14, 2014, the inspector observed that the shower rooms on the second and third floors were clean and without further soap build up or molds growing on contact surfaces. [s. 15. (2) (a)]

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 shower rooms and tub rooms throughout the home are kept clean and sanitary on an ongoing basis, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident # 001's rights to be groomed and cared for in a manner consistent with his or her needs, are fully respected and promoted.

Resident and staff interviews confirmed that resident # 001 has particular preferences and mannerism related to his/her shower habits that are regarded as challenging for the staff. Health record reviews, resident and staff interviews confirmed that resident # 001 did not receive a shower twice weekly as state in the plan of care, and that for periods of up to five consecutive weeks, the resident's right to be groomed and cared for was not respected and promoted. [s. 3. (1) 4.]

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Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 16th day of April, 2014

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	VERON ASH (535)
Inspection No. / No de l'inspection :	2014_274535_0004
Log No. / Registre no:	T-315-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 16, 2014
Licensee / Titulaire de permis :	601091 ONTARIO LIMITED 429 WALMER ROAD, TORONTO, ON, M5P-2X9
LTC Home / Foyer de SLD :	CEDARVALE TERRACE 429 WALMER ROAD, TORONTO, ON, M5P-2X9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Adele Lopes

To 601091 ONTARIO LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licensee shall ensure that resident # 001 is showered, at a minimum, twice a week and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Grounds / Motifs :

1. The licensee failed to ensure that resident # 001 is showered, at a minimum, twice a week.

Resident # 001 care plan indicated a shower given twice weekly, on Tuesdays by the bath team, and on Saturdays by the assigned PSW. Record review and staff interviews confirmed that the resident is particular about how and by whom the shower is provided. The resident prefers to have a shower with towels spread on the floor to stand on, and to perform the wash slowly which increases the time it takes to complete the shower. The staff providing the shower must be patient and remain with the resident to offer support as needed.

On March 14, 2014, staff interview and health record review confirmed that the resident was not showered on the scheduled Tuesday and Saturday for periods ranging from one week to five consecutive weeks from January to March 2014. A review of the record also indicated that the resident has developed redness or a rash in the groin; however he/she is refusing to allow staff to complete an assessment, but continues to apply naturopathic cream to the affected area.

The resident brought the concern forward to the associate director of care and the unit supervisor, however the plan of care was not discussed or revised by the staff. The inspector informed the director of nursing and administrator who were both unaware that the resident had missed consecutive weeks of scheduled showers. The director of nursing then met with the resident and the associate director of care to review and revise the plan of care to ensure that the resident receives the scheduled showers twice weekly. (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 18, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 16th day of April, 2014

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Veron Ash

Service Area Office / Bureau régional de services : Toronto Service Area Office