Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspection Branch

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Original Public Report

Report Issue Date: April 6, 2023
Inspection Number: 2023-1260-0001
Inspection Type: Complaint Critical Incident System
Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP
Long Term Care Home and City: Cedarvale Lodge Retirement and Care Community, Keswick

Lead Inspector	**Inspector Digital Signature**
Britney Bartley (732787)	Britney Bartley Digitally signed by Britney Bartley Date: 2023.04.12 15:05:53 -04'00'

Additional Inspector(s)
Amandeep Bhela (746)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 9-10, 13-16, 21-24, 2023

The following intake(s) were inspected:

- One intake related to resident to resident alleged physical abuse.
- Four intakes related to falls which resulted in significant change in health status.
- Two intakes related to responsive behaviours.
- One intake related to improper care of a resident.
- Two complaint intakes related to overall care.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Pain Management

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

1) The licensee failed to ensure that the Fall Prevention and Management Program policy was complied with for a resident. The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that any policy put in place must be complied with. Specifically, staff did not comply with the Long-Term Care Home's (LTCH) policy titled "Fall Prevention and Management Program", which indicated that if there is suspicion or evidence of injury the registered staff are to notify the Substitute Decision Maker (SDM).

Rationale and Summary

A critical incident (CI) report was submitted to the Director for an incident that resulted in significant change in a resident's health status. A resident was injured due to a fall and was transferred to a hospital by a nurse a few hours after their fall.

The resident's clinical records indicated that at the time of the fall, a nurse documented the resident complained of pain, had difficulty walking and their vital signs were a concern.

A few hours after the resident's fall another nurse assessed and documented the resident was in pain, unable to stand and their vital signs was a concern. This nurse called the resident's SDM and informed them of the resident's condition; the SDM agreed to send the resident to the hospital for further assessment. This was the first phone call made to the SDM to inform them of the resident's health status. There was no documentation found in the resident's clinical records that indicated the initial nurse had called the resident's SDM after the fall.

The Director of Care (DOC) confirmed at the time of the resident's fall a nurse did not follow the LTCH's fall prevention and management policy by calling the resident's SDM post fall.

By a nurse not informing the resident's SDM after the resident fell and sustained injuries, this delayed their opportunity to participate in the resident's care and potentially a delay in immediate treatment.

Sources: A resident's clinical records, Fall Prevention and Management Program VII-G-30.10, last revised December 2021, the LTCH's internal investigation file and interview with the DOC.

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2) The licensee failed to ensure that the Fall Prevention and Management Program policy was complied with for a resident. The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that any policy put in place must be complied with. Specifically, staff did not comply with the LTCH's policy titled "Fall Prevention and Management Program", which indicated that if there is suspicion or evidence of injury the registered staff are to notify the physician.

Rationale and Summary

A CI report was submitted to the Director for an incident that resulted in significant change in a resident's health status. A resident was injured due to a fall and was transferred to a hospital by a nurse a few hours after their fall.

The resident's clinical records indicated that at the time of the fall, a nurse assessed and documented the resident complained of pain, had difficulty walking and their vital signs were a concern. The resident's clinical records indicated the nurse documented a note in the physician book to follow up with the physician the following day.

A few hours after the resident's fall another nurse assessed and documented the resident was in pain, unable to stand and their vital signs was a concern. This nurse called the physician, informed them of the resident's condition and sent them to a hospital.

The DOC confirmed at the time of the fall the first nurse should have called the physician to inform them of the resident's post fall assessment and vital signs.

By the first nurse not informing the physician after the resident's fall and sustained injuries, there was potential risk to the resident not receiving immediate treatment.

Sources: A resident's clinical record review, Fall Prevention and Management Program VII-G-30.10, last December 2021, the LTCH's investigation file and interview with the DOC.

3) The licensee failed to ensure that the Fall Prevention and Management Program policy was complied with for a resident. The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that any policy put in place must be complied with. Specifically, staff did not comply with the LTCH's policy titled "Fall Prevention and Management Program", which indicated that registered staff are to monitor head injury as per the schedule on the form post-fall for signs of neurological changes.

Rationale and Summary

A review of the LTCH's policy titled "Fall Prevention and Management Program", indicated that registered staff are to initiate an assessment and complete as per protocol for any unwitnessed fall or if a head injury is suspected.

The assessment is scheduled to be completed:
Every 30 minutes for one hour
Every hour for four hours
Every eight hours for 56 hours

A CI report was submitted to the Director for an incident that resulted in significant change in a resident's health status. A resident was injured due to a fall and was transferred to a hospital by a nurse a few hours after their fall.

The resident's clinical records indicated a required assessment was not completed in its entirety at two specific times. The DOC acknowledged the LTCH's policy was not complied with, and the nurse was unable to ensure the resident was not suffering from any health concerns.

Failure to complete the assessment as required, put the resident at risk for potential delay in identifying any health changes or injuries as a result of the fall.

Sources: A resident's clinical records, the LTCH's investigation file and interview with the DOC.

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WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 19 (1)

The licensee failed to ensure that a resident was protected from abuse by another resident.

Section 2 of the Ontario Regulation 79/10 defines physical abuse as the "use of physical force by a resident that causes physical injury to another resident".

Rationale and Summary

A CI report was submitted to the Director regarding an alleged resident to resident altercation. The LTCH's investigation notes and interview with a nurse, indicated that they heard a resident requesting assistance, and observed the altercation. A nurse responded immediately and separated the two residents; the police and the physician were informed. The physician completed a medical form for the aggressive resident and they both were transferred to a hospital. One of the residents sustained injuries.

The nurse and the DOC confirmed an altercation occurred with two residents.

As a result of altercation there was actual harm and injury to one of the residents.

Sources: LTCH's investigation file, interviews with a nurse and the DOC.

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WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (6)

The licensee failed to ensure that a resident's initial plan of care was developed based on an assessment and information provided by the placement co-ordinator within the times provided for in the regulations upon admission.

Rationale and Summary

A complaint was submitted to the Director related to concerns around staff not providing a treatment for a resident.

A review of the resident's clinical records confirmed a treatment was not identified in the resident's initial plan of care. The DOC acknowledged that the treatment for the resident was not appropriately assessed, therefore the initial plan of care did not specify care approaches staff were to use when caring for the resident.

As a result of the home not developing an initial plan of care for the resident that was based on an assessment within the appropriate timeframe. There was potential risk to not providing the appropriate treatment.

Sources: A resident's clinical records and interview with the DOC.

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WRITTEN NOTIFICATION: Directives by Minister

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every operational Minister's Directive that applies to the long-term care home, the operational Minister's Directive was complied with.

In accordance with the Minister's Directive, COVID-19 guidance document for long-term care homes in Ontario, the licensee was required to ensure that all staff comply with masking requirements at all times, even when they are not delivering direct resident care.

A student Personal Support Worker (PSW) was observed entering the home with no face mask, the mask was in their hand and other staff were in the area entering and exiting the home. They walked over to the sign in book and then walked to the COVID -19 testing area. The student PSW indicated they were not wearing a face mask because they were rushing to sign in and was eating.
The DOC confirmed it is mandatory to wear a face mask when entering the home.

By the student PSW failing to not wear a face mask as required, the risk of transmission of infectious

disease increased.

Sources: Observations, COVID-19 guidance document for Long-term Care Homes in Ontario, last revised December 23, 2022, interviews with student PSW, and the DOC.

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WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting a resident.

A CI report was submitted to the Director for an incident that resulted in significant change in a resident's health status. A resident was injured due to a fall and was transferred to a hospital by a nurse a few hours after their fall.

Rationale and Summary

According to the LTCH's policy titled "Zero Lift and Protocol & Statement of Understanding", staff are not to manually lift any resident and are to use a mechanical lift as required. A review of a resident's clinical records and the LTCH's investigation file indicated a PSW, and two nurses manually lifted the resident from the floor to a mobility device. A nurse confirmed they manually transferred the resident from the floor to a mobility device because the resident was trying to stand up.

The DOC confirmed the PSW, and the two nurses did not safely transfer the resident and was to use a mechanical lift when transferring any resident from the floor to a mobility device.

Failing to use safe transferring techniques put the resident at actual risk of further injury.

Sources: A resident's clinical records, the LTCH's Zero Lift and Protocol & Statement of Understanding IV-M-10.10(a), last revised April 2022, the LTCH's investigation file, interviews with a nurse and the DOC.

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