Ontario

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

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
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torontodistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: December 28, 2022	
Inspection Number: 2022-1105-0002	
Inspection Type: Critical Incident System	
Licensee: Cedarvale Terrace LTC Inc. as general partner of Cedarvale Terrace LTC Limited Partnership	
Long Term Care Home and City: Cedarvale Terrace, Toronto	
Lead Inspector Christine Francis (740880)	**Inspector Digital Signature** Christine Francis Digitally signed by Christine Francis Date: 2023.01.04 13:50:26 -05'00'
Additional Inspector(s) Adelfa Robles (723)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 7-9, 12, 2022

The following intake(s) were inspected in this Critical Incident Systems (CIS) inspection:

- Intake: #00005311/CIS: #2591-000007-22 - related to improper treatment of resident by staff
- Intake: #00012054/CIS: #2591-000019-22 - related to falls prevention and management
- Intake: #00014346/CIS: #2591-000020-22 - related to improper transfer of resident by staff

The following intake(s) were completed in the Critical Incident Systems (CIS) inspection:

- Intake: #00005846/CIS: 2591-000017-21 - related to falls prevention and management
- Intake: #00007107/CIS: 2591-000009-22 - related to injury of unknown cause

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

Falls Prevention and Management
Infection Prevention and Control
Resident Care and Support Services

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 102 (7) 11.

The licensee has failed to ensure that there was a hand hygiene program in place in accordance with any standard issued by the Director.

The licensee failed to implement measures in accordance with the "Infection Prevention and Control Standard for Long-Term Care Homes, April 2022" (IPAC Standard). Specifically, section 10.1 stated that the licensee shall ensure that the hand hygiene program included access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR).

Rationale and Summary
It was observed that the Alcohol-Based Hand Rub (ABHR) at the Rapid Antigen Testing (RAT) area was expired.

Office Manager acknowledged that the ABHR was expired, and immediately discarded the expired product. Associate Director of Care (ADOC) indicated that these expired products may increase the risk of transmission of infection due to decreased efficacy.

Sources: Observations on December 7, 2022, and interviews with Office Manager and Associate Director of Care (ADOC).

[740880]

Date Remedy Implemented: December 7, 2022

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

Rationale and Summary
The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care (MLTC) regarding improper/incompetent treatment of a resident that resulted in harm or risk to the resident. CIS report indicated that the Personal Support Worker (PSW) assigned to the resident rolled the resident over in bed, and they sustained an injury during care.

The plan of care indicated that the resident required two-person assist for bed mobility and care. The home's investigation notes revealed that the PSW assigned to the resident was alone during care.

PSWs #111, #115, Registered Practical Nurse (RPN) #116 and Registered Nurse (RN) #114 all indicated that staff were expected to follow the resident's plan of care. PSW #115 stated that the incident would had been prevented if the resident's plan of care was followed. Assistant Director of Care (ADOC) acknowledged that staff assigned to the resident did not follow the resident's plan of care as specified.

There was actual harm to the resident when their plan of care was not followed.

Sources: CIS #2591-000007-2022, resident’s written plan of care, progress notes, investigation records, interviews with PSWs #111, #115, RPN #116, RN #114 and ADOC.

[723]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)

The licensee has failed to ensure that the staff who provided direct care to the resident were kept aware of the contents of the resident's plan of care in relation to their appropriate sling size and had convenient and immediate access to it.

Rationale and Summary
On December 8, 2022, Inspector #723 observed PSWs #110 and #111 complete the resident's transfer from chair to bed using a transfer device. The inspector observed the PSWs used a specified size transfer sling for the resident.

The resident's plan of care indicated that they required two-person assistance using a specific transfer device for all transfers. The resident's sling size was not included in the plan of care as indicated in the home's policy under Resident Safety titled, "Transfers."

PSW #110 who assisted with the resident's transfer stated that the size used was appropriate for the resident. PSWs #115 and #118 stated they would know the resident's sling size just by looking at the resident. RPN #121 stated that there was no documentation readily accessible for direct care staff to reference what sling size the resident was assessed for. The Physiotherapist (PT) and Nurse Manager (NM) stated that determining residents' sling sizes was an interdisciplinary approach and should be included in assessments upon admission, quarterly and during significant change. The PT and NM acknowledged that the resident's specified size was not included in the resident's plan of care.

The Quality Improvement (QI) Lead stated that they compiled the residents' sling sizes on April 26, and updated on December 9, 2022, in a tracking tool. Management had access to the information, but they

were not aware if direct care staff had immediate access to it. NM stated that the residents' sling sizes were available upon request by direct care staff to management.

There was a risk of injury to the resident when direct care staff were not aware of and did not have access to information related to the resident's assessed transfer sling size.

Sources: Observation of the resident, plan of care, Minimum Data Set (MDS) records, Resident Care and Services Manual Section: Resident Safety Subject: Transfers INDEX ID: E-20 revised date September 28, 2022, CVT Sling Record updated December 9, 2022, Quality Improvement Program Section III: Risk and Quality Indicators and Tools, interviews with PSW #110, RPN #121, PT, NM #117, QI Lead and other staff.

[723]

COMPLIANCE ORDER CO #001 Transferring and Positioning Techniques

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40

The Inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee must be compliant with O. Reg. 246/22, s. 40.

Specifically, the licensee must:

1. Review the contents of the compliance order with all PSWs and registered staff in the home.
2. Re-educate all PSW staff working in the home related to the home's policies on Equipment to Support Safety in Lifting, Transferring and Repositioning.
3. Document the education provided, including the content of the material reviewed, the date completed, staff attendance, and the individual who provided the education.
4. Conduct weekly lift and transfer audits on all units to ensure that staff use safe transferring and positioning devices or techniques for residents for a period of four weeks.

5. Maintain a written record of the completed audits including the name of the person who completed the audit, the date of the audit, name of the staff being audited, outcome of the audits and any corrective actions taken if required.

The licensee has failed to ensure that the staff used safe transferring and positioning devices or techniques when assisting residents #002 and #003.

Grounds

(i) The home submitted a CIS report for improper/incompetent treatment of resident #002 that resulted in harm or risk to the resident. Resident #002 sustained an injury as a result of the incident.

The home completed an investigation related to the incident. The home's policy indicated that staff were required to use the equipment and materials provided to protect the health and safety of both residents and staff. Resident #002's plan of care indicated that the resident was unable to bear weight and required a transfer device with two-persons for transfers. On an identified date, PSW #118 transferred the resident without using the specialized device or assistance from another staff.

During interview with resident #002, they stated that they recall the incident when they sustained the injury. PSW #118 stated that it was a mistake when they transferred resident #002 alone without the use of a transfer device. RN #114 stated that the incident would have been prevented if resident #002 was transferred using the transfer device. ADOC confirmed that during the home's investigation, the PSW involved did not use the transfer device to transfer resident #002.

Sources: Resident #002's plan of care, progress notes, Diagnostic Imaging Report, the home's investigation notes, Health and Safety Manual, Section: Safe Resident Handling Program Subject: Equipment to Support Safety in Lifting, Transferring and repositioning INDEX ID: O-45, revised date March 14, 2022, interviews with PSWs #118, RN #114 and ADOC.

[723]

(ii) On an identified date, Inspector #723 observed PSWs #110 and #111 complete resident #003's transfer from chair to bed using a transfer device. The Inspector observed that the sling size used did not visually fit the resident and was labeled with a co-resident's name and room number.

Resident #003 required two-person assistance using a transfer device for all transfers. The "CVT Sling Report" updated by the home's QI Lead on December 9, 2022, indicated that resident #003 should use a specified size. Home's policy indicated that staff to follow directions provided in the individual Resident Care Plan regarding the use of specific devices/lifting equipment, and ensure they were the correct device and sling size.

PSW #110 who assisted with the resident transfer stated that the sling was appropriate for resident #003. PSW #115, RN #114, PT and ADOC all verified that the sling size used was not appropriate for resident #003.

There was actual harm to resident #002 and an increased risk of injury for resident #003 when the staff failed to use the necessary and appropriate equipment to safely assist the residents during transfers.

Sources: Observation of resident #003, resident #003's plan of care, MDS records, home's CVT Sling updated December 9, 2022, Health and Safety Manual, Section: Safe Resident Handling Program Subject: Equipment to Support Safety in Lifting, Transferring and repositioning INDEX ID: O-45, revised date March 14, 2022, interviews with PSWs #110, #115, #118, RN #114, PT and ADOC.

[723]

This order must be complied with by February 8, 2023.

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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