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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 22, 2020	2020_595110_0014	009516-20	Critical Incident System

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

DIANE BROWN (110)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 6 am, 12, 13, 19 am, 2020.

A Critical Incident related to a resident fall during transfer with injury.

During the course of the inspection, the inspector toured the home, observed the residents,provision of care, reviewed clinical health records, hospital records and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with Director of Care, Assistant Director of Care, Register Nurses, Registered Practical Nurses, Physiotherapist, Personal Support Workers.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **1 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. (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 there was a lack of reassessment and the plan of care reviewed and revised at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

This Inspection Protocol was initiated related to a resident fall with injury. A PSW attended to resident #001 to provide morning care. The PSW was transferring the resident and the resident turned and slipped/fell to the floor. The resident experienced a significant change in health status.

A review of the resident's health record identified the resident was at risk of falls. The resident was assessed and received fall prevention treatments 2-3 times a week until an identified date. An interview with PT #103 identified that resident #001 was not provided with PT services after March 25, 2020 up until the resident's fall, a 6 week period, related to an interruption in PT services from COVID-19. Staff interviews, RPN #102 and RN #101 shared that the lack of PT treatments could have contributed to the resident's transfer decline and that the resident's plan of care had not been reassessed when the falls prevention treatment plan for PT exercises and strengthening was stopped. The PT #103 acknowledged the risk to resident #001 in that when PT treatments were suspended their overall endurance would go down and they would be at falls risk.

Sources: Progress notes, PT Therapy Minutes report, plan of care and staff interviews. [s. 6. (10) (b)]

2. Resident #002 was at high risk of falls. The resident was assessed and received fall prevention treatments a number of times a week until an identified date. An interview with PT #103 identified that PT services were suspended in the home after March 25, 2020. Resident #002 did not receive the fall prevention intervention for 16 weeks and during this time the resident sustained three falls. Staff interviews with RN #107 and RPN #102 identified that the resident's transfer tolerance declined during the period of time of no PT services.

A review of the resident's plan of care revealed it had not been reviewed and revised following the suspension of PT services.

Sources: Resident #002's plan of care, the PT Therapy Minutes and Report, progress notes and staff interviews. [s. 6. (10) (b)]

3. Resident #004 was assessed and received fall prevention treatments a number of times a week until an identified date.

An interview with PT #103 identified that that PT services were suspended in the home after March 25, 2020. Resident #004 did not receive the fall prevention intervention for 14 weeks. Staff interviews with RN #107 and RPN #102 identified that the resident's mobility status declined during the period of time of no PT services.

A review of the resident's plan of care revealed it had not been reviewed and revised following the suspension of PT services.

Sources: Resident #004's plan of care, the PT Therapy Minutes and Report, progress notes and staff interviews. [s. 6. (10) (b)]

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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (1) 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. O. Reg. 79/10, s. 49 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the home's Fall Prevention and Management Program provided for strategies to reduce or mitigate falls.

The home submitted a Critical Incident (CI) to the Ministry of Long Term Care reporting that resident #001 fell during a transfer. The resident experienced a significant change in health status. Staff interviews confirmed that the resident fell during a transfer with the required transfer device and staff assistance. The resident's plan however also delegated to the PSWs that the resident's transfer status changed during the day and the resident may require the another intervention when tired or weak. This resident had not received the care planned physiotherapy fall prevention treatments for 6 weeks prior to their fall related to the COVID-19 pandemic.

In separate interviews with RN #101, RPN #102 and PT #103 they identified that PSWs are not qualified to make a decision or assess the resident's transfer status. The PT identified this delegated decision making to PSWs was an identified risk to the resident.

The home's Fall Prevention and Management Program failed to provide for strategies to reduce or mitigate falls, by way of plans of care that directed PSW staff to assess and determine a resident's transfer status and the use of appropriate transfer equipment.

Sources: Plan of care and progress notes for resident #001. Critical Incident #2769-000003-30; staff interviews with RN #101, RPN, #102, #104, PTA #105, PT #103 and the home's Fall Prevention and Management Program - Policy # VII-G-30.10. [s. 49. (1)]

Issued on this 23rd day of December, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DIANE BROWN (110)
Inspection No. / No de l'inspection :	2020_595110_0014
Log No. / No de registre :	009516-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 22, 2020
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
LTC Home / Foyer de SLD :	Cedarvale Lodge Retirement and Care Community 121 Morton Avenue, Keswick, ON, L4P-2M5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Anna Urbanowicz

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

To The Royale Development GP Corporation as general partner of The Royale Development LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must be compliant with LTCHA, s. 6. (10).

Specifically, the licensee must:
1. Ensure that residents receive PTA services as required.

Grounds / Motifs :

1. The licensee failed to ensure there was a reassessment and the plan of care reviewed and revised at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

This Inspection Protocol was initiated related to a resident fall with injury. A PSW attended to resident #001 to provide morning care. The PSW was transferring the resident and the resident turned and slipped/fell to the floor. The resident experienced a significant change in health status.

A review of the resident's health record identified the resident was at risk of falls. The resident was assessed and received fall prevention treatments 2-3 times a week until an identified date. An interview with PT #103 identified that resident #001 was not provided with PT services after March 25, 2020 up until the resident's fall, a 6 week period, related to an interruption in PT services from COVID-19. Staff interviews, RPN #102 and RN #101 shared that the lack of PT

treatments could have contributed to the resident's transfer decline and that the resident's plan of care had not been reassessed when the falls prevention treatment plan for PT exercises and strengthening was stopped. The PT #103 acknowledged the risk to resident #001 in that when PT treatments were suspended their overall endurance would go down and they would be at falls risk.

Sources: Progress notes, PT Therapy Minutes report, plan of care and staff interviews. [s. 6. (10) (b)]

(110)

2. Resident #002 was at high risk of falls. The resident was assessed and received fall prevention treatments a number of times a week until an identified date. An interview with PT #103 identified that PT services were suspended in the home after March 25, 2020. Resident #002's did not receive the fall prevention intervention for 16 weeks and during this time the resident sustained three falls. Staff interviews with RN #107 and RPN #102 identified that the resident's transfer tolerance declined during the period of time of no PT services.

A review of the resident's plan of care revealed it had not been reviewed and revised following the suspension of PT services.

Sources: Resident #002's plan of care, the PT Therapy Minutes and Report, progress notes and staff interviews. [s. 6. (10) (b)]

Sources: Resident #002's plan of care, the PT Therapy Minutes and Report, progress notes and staff interviews.

(110)

3. Resident #004 was assessed and received fall prevention treatments a number of times a week until an identified date.

An interview with PT #103 identified that that PT services were suspended in the home after March 25, 2020. Resident #004's did not receive the fall prevention intervention for 14 weeks. Staff interviews with RN #107 and RPN #102 identified that the resident's mobility status declined during the period of time of no PT services.

A review of the resident's plan of care revealed it had not been reviewed and revised following the suspension of PT services.

Sources: Resident #004's plan of care, the PT Therapy Minutes and Report, progress notes and staff interviews.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to resident #001 because the resident was not reassessed with actions taken when PT/PTA services were suspended. The resident was placed at risk of falling.

Scope: The scope of this non-compliance was widespread as three of the three residents reviewed during the inspection who were receiving PT services did have their plan of care reviewed and revised when the services were suspended March 25, 2020.

Compliance History: Multiple WNs and VPCs were issued to the home related to different sub-sections of the legislation in the past 36 months.

(110)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jan 08, 2021

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
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
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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 22nd day of December, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DIANE BROWN

Service Area Office /
Bureau régional de services : Central East Service Area Office