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

Central East District
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Original Public Report

Report Issue Date: August 08, 2023
Inspection Number: 2023-1260-0002
Inspection Type: Complaint Critical Incident System
Licensee: The Royale Development GP Corporation as general partner of The Royale Developme
Long Term Care Home and City: Cedarvale Lodge Retirement and Care Community, Keswick

Lead Inspector	**Inspector Digital Signature**
Asal Fouladgar (751)	Asal Fouladgar Digitally signed by Asal Fouladgar Date: 2023.08.10 15:43:10 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 24-28, 31, August 1, 2023.

The following intake(s) were inspected:

- A complaint related to Prevention of Abuse and Neglect and Responsive Behaviours.
- A Critical Incident Report (CIR) related to Falls Prevention and Management.
- A CIR related to Prevention of Abuse and Neglect.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

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)
FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that when a resident was reassessed due to their care needs change, their plan of care was revised.

Summary and Rationale

During an observation, a posted transfer note identified in the resident's room which was indicating that the resident required a specific sling size with use of a mechanical lifting device. Further observation on the same day identified that a different sling size was being used for the resident.

The resident's plan of care indicated the same information that was posted in the resident's room. A relative recent progress note review indicated that the resident required the same size sling which was being used by staff at the time of observation for transferring the resident using a mechanical lifting device.

Personal Support Worker (PSW) #106 confirmed that the sling size indicated in the resident's care plan was not being used. The Director of Care (DOC) and the home's Physiotherapist (PT) confirmed that the resident required the same sling size which was already being used by staff and the resident's care plan should have been updated.

The DOC updated the resident's care plan accordingly.

Sources: Observations, the resident's clinical records, staff interviews.
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Date Remedy Implemented: July 25, 2023.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that PSWs #100, #105, and Registered Practical Nurse (RPN) #101 used safe transferring and positioning devices or techniques when assisting a resident.

Summary and Rationale

A CIR was submitted to the Director related to fall of a resident which resulted in significant injury. According to the home's policy titled "Zero Lift and Protocol & Statement of Understanding", staff were directed not to manually lift any resident and to use a mechanical lift with the presence of two staff as required.

The resident's clinical records indicated they were at moderate risk for falls and required a specific lifting device for transfers.

The home's investigation notes indicated that PSW #105 transferred the resident using a mechanical lifting device without a second staff's assistance which resulted in the resident's improper position on their mobility device. This was also confirmed through review of the home's recorded video footage. The resident fell when PSW #100 attempted to re-adjust the resident's mobility device. According to the investigation notes and review of the recorded video footage, PSW #100 and RPN #101, manually lifted the resident from the floor to their mobility device after the fall incident.

PSW #100 confirmed that the resident was not in a proper position when they initially received them, and they did not use a mechanical lifting device to transfer the resident from the floor back to their mobility device after the fall incident. The DOC confirmed the same and indicated when PSW #100 moved the resident's mobility device, they failed to guard the resident. The DOC confirmed that PSWs #100 and #105, and RPN #101 did not use safe transferring techniques or devices when assisted the resident which was also against the home's safe transferring policy.

Failing to use safe transferring techniques put the resident at actual risk of harm where they fell and sustained an injury.

Sources: The resident's clinical records, CIR, the home's policy titled "Zero Lift and Protocol & Statement of Understanding", IV-M-10.10(a), last revised June 2022, the home's investigation notes, interviews with staff.
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