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
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: July 14, 2025
Original Report Issue Date: June 11, 2025
Inspection Number: 2025-1260-0002 (A1)
Inspection Type: Complaint Critical Incident
Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP
Long Term Care Home and City: Cedarvale Lodge Community & Retirement Living, Keswick

AMENDED INSPECTION SUMMARY

This report has been amended to:
CO #001 was rescinded

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 2, 3, 4, 5, 2025

The following intake(s) were inspected:

- One intake related to improper care of a resident, and
- One intake related to concerns of a resident fall.

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

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee failed to ensure that staff reviewed the resident's care plan when the resident was improperly transferred, that resulted in an injury.

The resident's plan of care indicated that they required a specific intervention for transfers.

Two direct care staff members, confirmed they did not review the resident's care plan prior to providing care that resulted in injury.

Sources: Critical Incident Report (CIR), resident's Progress Notes, the home's investigation file, interviews with staff.
[741757]

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
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that the resident was properly assisted, which resulted in an injury.

The resident's care records indicated that they required a specific intervention for transfers.

The Associate Director of Care (ADOC) confirmed that the resident was unsafely assisted and sustained an injury.

Sources: CIR, resident's Progress Notes, the home's investigation file, interviews with staff. [741757]

COMPLIANCE ORDER CO #001 Duty to protect

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. The home will complete a Root Cause Analysis (RCA) of the identified resident's fall incident that includes multidisciplinary involvement of managers, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and Client Service Aides (CSA). Keep a documented record of the RCA, the date the RCA was completed, and who attended. This document will be kept and available to the inspector upon request.
2. The home will analyze the results of the RCA and identify and document any gaps. This

document will be kept and available to the inspector upon request.

3. If any gaps are identified with part #2 of the order, the home will provide education to all nursing staff. Keep a documented record of the date, who provided the education, the content of the education, and staff names and signatures.
4. Re-evaluate and update any policies, procedures, protocols and or training related to fall prevention, and monitoring in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Grounds

The licensee failed to ensure a resident was protected from neglect.
Section 7 of the Ontario Regulation 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or wellbeing, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."
The Ministry of Long Term Care (MLTC) received a concern that the death of a resident was preventable and the home neglected to monitor the resident for a specific intervention.

The identified resident was admitted with a history of a specific safety risk. The home completed a safety risk assessment upon admission which further supported the resident being identified as a high risk for safety.

A Registered staff member indicated that due to the resident's risk of safety, they were not to be left unsupervised.

The resident was found on the floor in their room unsupervised and transferred to hospital with an upper body injury. The resident returned to the home, and deceased. The death certificate indicated the immediate cause of death to be the identified incident.

Actual harm occurred when the resident was left unsupervised in their room, and later deceased.

Sources: resident's progress notes, POC documentation, plan of care, investigation notes, medication records, and interviews with the Physician, Substitute Decision Maker, and other staff.

This order must be complied with by July 16, 2025

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

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.