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

Public Report

Report Issue Date: June 26, 2025
Inspection Number: 2025-1260-0003
Inspection Type: 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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 24 - 26, 2025

The following intake(s) were inspected:

- An intake related to prevention of abuse and neglect

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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 licensee failed to ensure a resident was protected from sexual abuse by a staff member.

On a specified date, two staff observed on a monitoring camera another staff member enter a resident's room and had exhibited a sexually inappropriate behaviour towards a resident.

Sources: Critical Incident Report (CIR), Video footage, Home's Investigation records, resident's clinical records, interviews with Director of Care (DOC) and other staff.

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that any alleged abuse of a resident was reported immediately to the Director.
A resident reported an incident of an allegation of abuse on a specified date to a staff, the alleged abuse was not reported to the Director.

Sources: Resident's clinical records and statement, interviews with the resident and DOC.

WRITTEN NOTIFICATION: Police Notification

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The Licensee failed to ensure that the appropriate police service is immediately notified of any alleged abuse of a resident.
During interviews with staff for a CIR on a specified date, revealed a pervious incident report by a resident of an alleged abuse that had occurred a couple of months prior on a specified date.
Police services was not notified of the alleged abuse.

Sources: Resident's clinical records and statement, interviews with the resident and DOC.

WRITTEN NOTIFICATION: Dealing with Complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

The licensee failed to ensure that a documented record was kept in the home that included the nature of each verbal or written complaint.

The home's complaint log was requested to review any complaints brought forward related to care. The DOC stated that they were aware of complaints but was unable to locate a complaints log for the home.

Sources: Resident's clinical records and statement, interviews with the resident and DOC.

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