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

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Original Public Report

Report Issue Date June 29, 2022
Inspection Number 2022_1105_0001
Inspection Type
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

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
Matthew Chiu (565)

Additional Inspector(s)
Reji Sivamangalam (739633)

Inspector Digital Signature
Matthew Chiu Digitally signed by Matthew Chiu Date: 2022.07.25 13:19:41 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 14-16, 22, and 23, 2022.

Inspector Kwesi Douglas (736409) was also present during this inspection.

The following intake(s) were inspected:

- Intake #008857-22 (Complaint) related to alleged improper care and treatment of resident
- Intake #009229-22 (Complaint) related to resident charges

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

- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Reporting and Complaints
- Resident Care and Support Services
- Resident Charges and Trust Accounts

INSPECTION RESULTS

WRITTEN NOTIFICATION PLAN OF CARE

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee has failed to ensure that one resident's substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's medication plan of care.

Rationale and Summary:

The resident was referred to their physician to re-assess the use of medication for their responsive behaviours. A medication was ordered and it was administered to the resident starting the next day.

The resident's SDM was involved in their medication plan of care. Related to the above-mentioned medication order, the home was unable to get in touch with the resident's SDM until eight days later. The medication was administered to the resident for nine days prior to the SDM being given the opportunity to participate fully in the resident's medication plan of care.

Sources: Resident's progress notes, physician orders, electronic medication administration records; interviews with the SDM, registered nurse (RN), and Director of Care (DOC). [565]

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 102. (2) (b)

The licensee has failed to ensure that the requirement of proper removal and disposal of personal protective equipment (PPE) included in the infection prevention and control (IPAC) standard issued by the Director was implemented by a staff.

Rationale and Summary:

A resident was on droplet and contact precautions (DCP). A personal support worker (PSW) was observed, wearing full PPE, exiting the resident's room after providing care. The PSW went to other home areas and then re-entered the resident room with the same PPE to continue providing care to the resident.

The IPAC Manager stated that staff should discard their PPE when coming out of a resident's room who was on DCP before going to other home areas.

There was a risk of infection transmission to other residents and staff when the PSW went to common areas of the home without removing their PPE.

Sources: Observation; resident's progress notes, home's respiratory line list; interviews with the PSW and IPAC Manager. [739633]

WRITTEN NOTIFICATION RESIDENT CHARGES

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 91. (1) 1

The licensee has failed to ensure that one resident was not charged more than the amount provided for in the regulations for the basic accommodation provided.

Rationale and Summary:

The resident's basic accommodation charges were paid in full for a period covering four consecutive months. Within the same month, the home made two additional withdrawals of the total accommodation charges covering the same four-month period from the resident's bank account on two separate days.

The accountant reported that the charges were made in error and the two withdrawals should not have been made from the resident's account. The overcharged amount was not reimbursed completely to the resident until approximately six months later.

Sources: Resident's bank account statement, Long Term Care Home Accommodation Agreement; interviews with the SDM, Accountant and Executive Director (ED). [739633]

WRITTEN NOTIFICATION DEALING WITH COMPLAINTS

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 101. (1) 2.

The licensee has failed to ensure that for those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint was provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 was provided as soon as possible in the circumstances.

Rationale and Summary:

A resident's SDM sent a complaint letter to the home complaining about unauthorized withdrawals from the resident's bank account by the home.

The home acknowledged receipt of the complaint the next day, but it did not include a date by which complainant could reasonably expect a resolution. The SDM did not receive any follow-up response from the home and sent another letter to the home approximately a month later to

follow-up with their concerns. The ED acknowledged the follow-up response was not provided as soon as possible as required.

Sources: Complaint letters; interviews with the SDM and ED. [739633]

WRITTEN NOTIFICATION COMPLAINTS PROCEDURE – LICENSEE

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 22. (1)

The licensee has failed to ensure that the written complaints received from one resident's SDM concerning unauthorized withdrawals from the resident's bank account were immediately forwarded to the Director.

Rationale and Summary:

The home received two complaint letters from the resident's SDM complaining that the home made unauthorized withdrawals of funds from the resident's bank account on two different dates. The home did not forward the written complaints to the Director.

Sources: Complaint letters; interview with the ED. [739633]