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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: October 23, 2023
Inspection Number: 2023-1105-0004
Inspection Type: Critical Incident
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	**Inspector Digital Signature**
Lisa Salonen Mackay (000761)	Lisa A Salonen Mackay Digitally signed by Lisa A Salonen Mackay Date: 2023.10.25 15:04:50 -04'00'

Additional Inspector(s)
Adelfa Robles (723)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 5, 6, 12, 2023

The inspection occurred offsite on the following date(s): October 10, 2023

The following intake(s) were completed in this Critical Incident (CI) inspection:

- Intake: #00095411 / CI#2591-000011-23 related to outbreak
- Intake: # 00092394-23 / CI # 2591-000008-23 related to falls prevention and management,
- Intake: #00096084 / CI # 2591-000012-23 and Intake: # 00022141 / CI # 2591-000005-23 related to injury of unknown

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.

The licensee has failed to ensure that resident's wheelchair was placed in an upright position during meals.

During a meal observation a resident was observed on a titled wheelchair while being fed by a Unit Supervisor (US). The US repositioned resident's wheelchair to an upright position when it was brought to their attention.

The resident's written plan of care indicated that they required staff assistance after meals. Nutrition Risk Assessment indicated that they were at risk related to chewing difficulties and required a modified diet texture. The home's policy indicated that residents who needed assistance with feeding would have their nutritional needs met in a safe and comfortable environment.

The US confirmed that resident's wheelchair was not in an upright position when they assisted the resident during the meal. The US and Director of Care (DOC) both stated that staff were expected to place residents in an upright position during meals unless otherwise indicated. The DOC stated that there was a risk of aspiration and or choking if residents were not placed in an upright position during meals.

There was a risk of aspiration or choking for this resident when their wheelchair was tilted during meals.

SOURCES: Dining observation, Home's Policy on Activities of Daily Living Index ID: D-25, Subject: Assistance with Feeding, resident plan of care, completed nutrition risk assessment, interviews with US and DOC.
[723]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #002 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 implement a protocol issued by the Director with respect to infection prevention and control.

The license has failed to ensure that masking was used in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard) as required by Additional Requirements 9.1(d) under the IPAC Standard.

A Laundry Aide was observed in hallway without a mask. A Physiotherapist Assistant informed the Laundry Aide that masks were available at the nursing station. The Laundry Aide acknowledged awareness of masking expectation, walked past the nursing station and went into the elevator with no mask.

The IPAC Lead and Administrator acknowledged that all staff were expected to wear a mask in the home.

There was a risk of infection transmission to other residents and staff when the Laundry Aide staff was observed not wearing a mask.

Sources: Observations, Review of IPAC Standards and interviews with IPAC Lead, Laundry Aide and Administrator.
[000761]