Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 17, 2018	2018_759502_0010	012293-18	Critical Incident System

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Cheltenham Care Community
5935 Bathurst Street NORTH YORK ON M2R 1Y8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JULIENNE NGONLOGA (502)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 26, 27 and 28, 2018.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Relation Coordinator/ Social Work (SW), and residents.

During the course of this inspection, the inspector observed resident care, observed staff and resident interactions, reviewed the residents' health records, staff schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to protect residents from abuse by anyone.

Review of a critical incident report system submitted to the Ministry of Health and Long-Term Care (MOHLTC) and the resident's progress notes indicated that:
- On an identified date and time resident #001 had an interaction with resident #005 with no injury. Resident #001 denied the incident and stated "I did not touch them", and started exhibiting an identified responsive behaviour. A few minutes after, resident #001 stopped their behaviour and verbalized "I don't like them".
- five weeks after admission, resident #001 sounded upset talking to resident #002, the current roommate, stating " everything was ok when you were not here, now everything is a problem". Once in the resident's room, the registered nursing staff observed resident #001 pointing their finger to resident #002. The roommate, resident #002 was observed sitting on their bed listening to resident #001 with no response.
- Ten weeks after admission, resident #002 was heard calling "Help! Help!". According to staff #106, when they entered the room, they observed resident #002 lying in bed and resident #001 pushing on an identified area of resident #001 resulting in redness around the neck. Resident #002 stated, "that resident was trying to hurt me" and appeared frightened and scared according to staff.

Review of resident #001's current plan of care, indicated that resident #001 had a moderate cognitive impairment related to an identified medical condition. Under focus behaviour problem it noted that the resident may exhibit specified responsive behaviours and specified interventions were developed and implemented.

Review of the admission package under Behavioural Assessment Tool completed prior to the admission in the home and interview with the staff #105 indicated that resident #001 can get bothered by noise.

On admission resident #001 shared a room with resident #005, who ambulated independently. Two weeks after admission, resident #001 was transferred temporarily to an identified room as result of an interaction with resident #005 while the home was looking for a suitable roommate for them. Six weeks after, resident #001 was transferred to the same room with resident #002, as they were dependent on staff for transfer and mobility and used a specified equipment all the time, which was not considered to be noisy.

In an interview staff #100 indicated that they were aware that resident #001 did not like their roommate as there was another incident with the previous roommate, and that the resident currently was not sharing a room with another resident.

In separate interviews staff #105, #102, and #104 indicated that the resident behaviour triggers were not confirmed, pending the external specialized assessment. However, they were aware that they resident did not like the noise. Staff #104 indicated that they were not aware that the noise from specialized equipment would bother the resident and triggered their behaviour. [s. 19.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Review of a critical incident report system submitted to the MOHLTC indicated that on identified date and time resident #002 was heard calling "Help! Help!". According to staff #106, when they entered the room, they observed resident #002 lying in bed and resident #001 pushing on an identified area of resident #001 resulting in injury. Resident #002 stated, "that resident was trying to hurt me" and appeared frightened and scared according to the staff.

Review of resident #001’s written plan of care under behaviour problems indicated that the resident exhibits identified responsive behaviours related to a specified medical condition, specified interventions were implemented for all shifts.

Record review of a specified documentation record for an identified period of time showed that the provision of care were not documented on 15 occasions.

In an interview, staff #104 acknowledged that staff provided care on the above dates and did not document the care they had provided. [s. 6. (9) 1.]

Issued on this 18th day of July, 2018

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.