Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 21, 2020	2019_751649_0024	020397-19, 020398-19	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

JULIEANN HING (649)

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): December 3, 4, 5, 6, 9, 10, 11, off-site 13, 17, 20, 23, and 24, 2019.

Log #020397-19/ Critical Incident System (CIS) #0922-000088-19 and log #020398-19/ CIS #0922-000089-19 are related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the assistant director of care (ADOC), behavioral support recreation therapist (BSRT), registered nurses (RNs), registered practical nurses (RPNs), and personal support workers (PSWs).

During the course of the inspection the inspector reviewed residents' health records, staffing schedules, investigation notes and conducted observations.

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.
- **1 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	Légende 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 ensure that residents #001 and #002 were protected from

abuse.

In accordance with the definition identified in section 2(1) of the Regulation 79/10 "physical abuse" means the use of physical force by a resident that causes physical injury to another resident (mauvais traitement d'ordre physique").

Two critical incident system (CIS) reports were submitted by the home to the Ministry of Long-Term Care (MLTC), related to an incident of physical abuse involving residents #001 and #002. According to the first CIS report there was an incident of resident to resident physical abuse, whereby resident #001 was observed by PSW #109 hitting resident #002. The second CIS report was submitted for a fall, that resident #001 sustained as a result of their interaction with resident #002 and was transferred to hospital for further assessment.

Further review of the two CIS reports indicated that resident #001 sustained an injury as a result of the interaction they had with resident #002.

Review of the home's investigation notes indicated in a statement from resident #002 that they had turned on an identified object. Resident #001 tried to turn the identified object off and resident #002 held their hand. Resident #001 then pushed resident #002 and resident #002 pushed back and both residents fell.

In an interview PSW #109 they told the inspector that resident #002 was touching another identified object and resident #001 was getting excited. According to the PSW they reassured resident #001 that resident #002 was okay and both residents settled, and they moved on to another area of the dining room and started to apply the clothing protectors on other residents. They heard an excitement and when they looked up, they saw resident #001 hitting resident #002 but was too far away to intervene. Resident #001 hit resident #002 who lost their balance and fell forward and resident #002 fell backward. The PSW told the inspector that no other staff were present in the dining room at the time of the incident, so they left the residents and went to the person at the reception to request assistance as resident #001 was observed to have sustained an injury. According to the PSW when they returned to the dining room resident #001 was trying to throw something at resident #002. In a follow-up interview with PSW #109 they acknowledged that physical abuse had occurred between residents #001 and #002.

In an interview with RN #112 who was working the day the incident took place, told the inspector that they received a call from the reception asking for a nurse to go to the

dining room. They recalled that the incident occurred between the two residents over an identified object in the dining room. They further explained that resident #001 did not like the identified object on and when they left the dining room they would then turned the identified object on. The RN acknowledged that physical abuse had occurred between the the two residents.

In an interview with ADOC #113 who was in the home when the incident occurred, told the inspector that an argument resulted between residents #001 and #002 over an identified object in the dining. According to the ADOC resident #001 is territorial over the identified object and most residents knew this, however on that day of the incident resident #002 wanted to turn the identified object on and resident #001 did not want the identified object on. The ADOC told the inspector that the home was unable to determine who initiated the incident as there was indication that both residents were hitting each other according to witnesses in the dining room. The ADOC acknowledged that physical abuse had occurred between residents #001 and resident #002. [s. 19. (1)]

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, to be implemented voluntarily.

Issued on this 4th day of February, 2020

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

Original report signed by the inspector.