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
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Original Public Report

Report Issue Date: February 22, 2023	
Inspection Number: 2023-1007-0002	
Inspection Type: Critical Incident System	
Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.	
Long Term Care Home and City: Cheltenham Care Community, North York	
Lead Inspector Henry Chong (740836)	**Inspector Digital Signature** Henry A Chong Digitally signed by Henry A Chong Date: 2023.02.23 11:56:04 -05'00'
Additional Inspector(s) Wing-Yee Sun (708239)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 8-10, 13-16, 2023

The following intake(s) were inspected:

- Intake: #00007778 - [CI: 0922-000011-22] Medication incident
- Intake: #00009270 - [CI: 0922-000038-22] Fall with injury
- Intake: #00013777 - [CI: 0922-000042-22] Medication incident
- Intake: #00015116 - [CI: 0922-000044-22] Fall with injury
- Intake: #00016650 - [CI: 0922-000045-22] Resident to resident physical abuse
- Intake: #00017766 - [CI: 0922-000001-23] Staff to resident abuse
- Intake: #00018895 - [CI: 0922-000003-23] Fall with injury

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

Medication Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 102 (7) 11.

The licensee has failed to ensure that their hand hygiene program was implemented in accordance with any standard issued by the Director.

Specifically, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s. 10.1 stated that the licensee shall ensure that the hand hygiene program included access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR).

Rationale and Summary
Two bottles of expired 75% ABHR were found in the isolation caddy for two different rooms on an identified date.

A staff member and the Director of Environmental Services acknowledged they were informed about the expired ABHR and immediately discarded the product.

The Director of Care (DOC) acknowledged that expired ABHR could have decreased effectiveness against bacteria, viruses, and infection control.

Sources: Observations, and interviews with staff, Director of Environmental Services and the DOC.

Date Remedy Implemented: February 8, 2023

[708239]

WRITTEN NOTIFICATION: Reporting critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22 s. 115 (1) 5.

The licensee has failed to ensure that a disease outbreak was immediately reported to the director.

Rationale and Summary
On an identified date, a disease outbreak was declared in the home. The home reported the incident to the Director on the following day. The DOC stated that the outbreak was not reported immediately.

Sources: CIS report #0922-000004-23, and interview with the DOC.

[740836]

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021 s. 24 (1)

The licensee has failed to ensure that resident #002 is protected from physical abuse by resident #001.

Section 2 (1) of the Ontario Regulation 246/22 defines physical abuse as “the use of physical force by a resident that causes physical injury to another resident."

Rationale and Summary
On an identified date, resident #001 and resident #002 were involved in a physical altercation. The residents were immediately separated.

A staff member stated that they witnessed the physical altercation between resident #001 and #002.

The DOC stated that resident #002 experienced physical abuse from resident #001. As a result of the incident, resident #002 sustained an injury.

Sources: Critical Incident System (CIS) report #0922-000045-22, resident #001 and resident #002's clinical records, and interviews with the DOC and other staff.

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WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to comply with the procedure to report witnessed or suspected abuse of resident #005 and #006 immediately.

In accordance with O. Reg 246/22 s. 11 (1) b, the licensee is required to ensure that there is a written policy to promote zero tolerance of abuse and neglect of residents in place, and the policy must be complied with.

Specifically, staff did not comply with the home's policy "Prevention of Abuse and Neglect of a Resident, VII-G-10.00" last revised October 2022 which was captured as part of the licensee's Zero Tolerance policy for abuse of a resident by anyone.

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of resident #005 and #006 was complied with.

Rationale and Summary
(1) The licensee's policy "Prevention of Abuse and Neglect of a Resident" directed staff to immediately inform the nurse in charge of any witnessed or suspected abuse of a resident.

On an identified date, a staff member informed the DOC that there was an allegation of verbal abuse by a different staff member towards resident #005. The staff member allegedly overheard the other staff member verbally threaten the resident. When this concern was first brought to the DOC's attention, it was reported to have occurred months prior.

The staff member acknowledged they were unable to recall the exact date of the alleged verbal abuse but reported it occurred several months prior. Staff and the DOC acknowledged that they were expected to report the suspicion of abuse immediately but did not.

Sources: CIS report #0922-000001-23, licensee's policy "Prevention of Abuse & Neglect of a Resident, VII-G-10.00" last revised October 2022, and interviews with staff and the DOC.

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Rationale and Summary
(2) The licensee's policy "Prevention of Abuse and Neglect of a Resident" directed staff to immediately inform the nurse in charge of any witnessed or suspected abuse of a resident.

On an identified date, a staff member informed the DOC that there was an allegation of physical abuse by a different staff member towards resident #006.

The staff member alleged that the resident and other staff member had a physical interaction with each other, several months prior.

The DOC acknowledged that the staff member was expected to report the suspicion of abuse immediately but did not.

Sources: CIS report #0922-000001-23, licensee's policy "Prevention of Abuse & Neglect of a Resident, VII-G-10.00" last revised October 2022, and interview with the DOC.

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