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: January 10, 2024

Inspection Number: 2023-1007-0004

Inspection Type:
Critical Incident

Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.

Long Term Care Home and City: Cheltenham Community, North York

Lead Inspector	**Inspector Digital Signature**
Yannis Wong (000707)	Yannis Wong Digitally signed by Yannis Wong Date: 2024.01.11 09:13:49 -05'00'

Additional Inspector(s)
Lisa Salonen Mackay (000761)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: December 20-22, 28-29, 2023 and January 2-4, 2024.

The following intakes were inspected on the Critical Incident (CI) inspection:
• Intake: #00097354 – [CI: #0922-000032-23] – Alleged staff to resident physical abuse
• Intake: #00099491 – [CI: #0922-000038-23] – Alleged resident to resident physical abuse
• Intake: #00102716 – [CI: #0922-000042-23] – Fall resulting in injury

The following intake was completed in the CI inspection:
• Intake: #00097777 – [CI: #0922-000034-23] - Fall resulting in injury

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for a resident set out clear directions for staff to ensure the resident's falls prevention device was functioning properly.

Rationale and Summary

Resident #002 was at high risk of falls and had a falls prevention device. There were multiple dates where the device was not functioning, including a date when the resident sustained a fall with injuries.

The resident's care plan stated the device had been removed by the resident in the past. In the written plan of care, there were no clear directions to staff related to the frequency at which the device should be checked to ensure it was functioning properly.

Associate Director of Care (ADOC) stated that staff should have been checking a few times per shift to ensure the resident was not removing the device. They confirmed the care plan did not have clear directions to staff on frequency of completing this check.

Failure to provide clear directions to staff in the written plan of care could lead to the delay in staff's response to resident #002 and increase their risk for falls-related injuries.

Sources: Interviews with staff including ADOC; resident #002's clinical records. [000707]

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

The licensee has failed to ensure that resident #003 was protected from physical abuse by resident #004.

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

Rationale and Summary
Resident #004 had a history of physical responsive behaviours toward other residents when the resident's space was invaded. There was a physical altercation where resident #003 grabbed resident #004 and then resident #004 pushed resident #003. This led to resident #003 falling to the floor and sustaining injuries.

Registered Practical Nurses (RPN's) #111, #112 and Associate Director of Care (ADOC) all acknowledged that resident #004 physically abused resident #003 on October 14, 2023.

There was physical harm to resident #003 as a result of the physical abuse incident.

Sources: Resident #003 and #004 clinical records, interviews with RPN #111, #112 and ADOC and home's investigation notes. [000761]

WRITTEN NOTIFICATION: Maintenance services

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (b)
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment

The licensee has failed to ensure that all devices in the home are kept in good

repair.

Specifically, resident #002's falls prevention device was not working.

Rationale and Summary
Resident #002 had an unwitnessed fall and was found on the floor. The resident sustained an injury and was transferred to hospital for treatment. The resident had a falls prevention device and Personal Support Worker (PSW) #107 and Registered Nurse (RN) #108 stated the device was not working at the time of the resident's fall.

RN #108 identified the device was not working and replaced it on the same day. It is unknown when the device stopped working. ADOC #107 confirmed the device was not maintained in good repair.

Failure to ensure resident #002's falls prevention device was in good repair resulted in a delay in staff responding to the resident's fall.

Sources: Interviews with PSW #107, RN #108, and ADOC #107; resident #002's clinical records. [000707]