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

Public Report

Report Issue Date: December 13, 2024

Inspection Number: 2024-1007-0003

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 25, 26, 27, 28, 2024 and December 2, 3, 4, 5, 2024
The inspection occurred offsite on the following date(s): November 29, 2024, and December 6, 9, 2024

The following Critical Incident (CI) intake(s) were inspected:

- Intake: #00125018 – alleged abuse from resident to resident
- Intake: #00130337 - unexpected death of a resident
- Intake: #00132639 – alleged abuse of resident
- Intake #00127594 and #00127591 related to sudden death of a resident

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

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

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by someone that resulted in harm or risk of harm to the resident immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary

An incident of alleged sexual abuse occurred on a specified date to a resident with cognitive impairment. The home performed investigation, informed the police and submitted the Critical Incident (CI) report three days later because of the close relation of the alleged abuser with the resident.

Sources: CI report and interview with the DOC.

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WRITTEN NOTIFICATION: Reporting and complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

Dealing with complaints

s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the

home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.
The licensee has failed to ensure that when they received a report of alleged sexual abuse to a resident, an investigation was commenced immediately.

Rationale and Summary

On a specified date, it was reported to registered staff that suspected abuse or unconsented sexual activity happened to a resident and an investigation was not commenced immediately.

The resident had impaired ability for making decisions and consenting to sexual activities.

The suspected intimate activities were noted by staff several times and registered staff or management were not informed in order for an investigation to be initiated immediately.

Sources: CI report, observation, resident's clinical record and interviews with staff. [210]

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