Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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

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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
Jul 15, 2019	2019_780699_0013	001977-19, 005778-19, 008161-19, 008639-19, 008723-19	Complaint

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

PRAVEENA SITTAMPALAM (699), HELENE DESABRAIS (615)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 19-21, 24-28, 2019.

The following complaint intakes was inspected during this inspection:
Log #008161-19, 008639-19, and 008723-19 related to dining concerns; and
Log #005778-19 related to fall and hygiene concerns.

The following Critical Incident System (CIS) intake related to falls were completed during this Complaint inspection:
Log #001977-19, CIS 0922-000006-19.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Director of Environmental Services (DES), registered nurse (RN), registered practical nurse (RPN) and personal Support Workers (PSW).

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee failed to ensure that for resident #024, that there is a written plan of care in relation to responsive behaviour during care.

The Ministry of Health and Long-term Care (MOHLTC) received a complaint related to resident #024 having identified care concerns. A CIS report was submitted to the MOHLTC related to resident #024 having a fall which resulted in an identified injury.

Review of the plan of care did not indicate what type of responsive behaviours resident #024 exhibited.

In an interview with PSW #115, they stated that resident #024 would require a specific level of assistance for all care depending on their resident's identified behaviours.

In an interview with RN #117, they indicated that resident #024 has responsive behaviours during a specified type of care. They further stated that for resident #024, the plan of care should indicate that the resident can exhibit an identified responsive behaviour during care and may require a specified level of assistance to provide care.

In an interview with ADOC #106, they stated that resident #024 requires a specific level of care during an identified care due their identified responsive behaviour. They further

acknowledged that it was not clear on the plan of care what type of responsive behaviour the resident exhibits and that the resident requires a specified level of care during care related to these behaviours. [s. 6. (1) (a)]

2. The licensee failed to ensure that for resident #024, their plan of care was followed.

Review of the CIS report indicated that resident #024 was assisted by PSW #115 and PSW #116 to be transferred. Resident #024 fell after being assisted by staff and was noted to have an identified change of health status. Resident #024 was sent to hospital and subsequently diagnosed with a specified injury.

Record review of resident #024's care plan at the time of the fall indicated the following for a specific activity of daily living (ADL):
-require a specified number of team members for care.

In an interview with PSW #115 they stated they transferred the resident with the assistance of PSW #116. PSW #116 left the room after assisting with the transfer and PSW #115 remained with resident #024. They further stated that they turned away from the resident and the resident fell.

In an interview with assistant director of care (ADOC) #106 and DOC #101, they stated that for resident #024, they required a specific number of team members to proivde assistance for an identified ADL as the resident has identified responsive behaviours. They acknowledged that for resident #024, their plan of care was not followed. [s. 6. (7)]

3. The licensee has failed to ensure that staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it related to the resident's dining experience.

A complaint was submitted to the MOHLTC related to residents not being fed and staffing issues. An additional complaint was submitted to the MOHLTC related to issues with dining services and staffing issues.

On June 20, 2019, Inspector #523 observed DES #103 entering the kitchen area, grabbing several cutlery sets and came to the dining room and started distributing the sets on the residents' table. One of the residents told the DES "this resident takes a specified type of cutlery".

Inspector #523 then asked the DES which residents that were sitting at the table required knives and forks and DES #103 answered that they did not know who was sitting at the table and then referenced to the seating map on the wall but was unable to find who was supposed to be sitting at this table. Inspector #523 then asked DES #103 if they were aware of the plan of care specific to dining or eating assistance or special utensils used by resident or other residents and they replied "no."

Inspector #523 shared concern with ED #100 and they said that the seating map and books needed to be updated. ADOC #106 approached Inspector #523 and stated that those residents were not supposed to be at the table but because they had identified behaviours, they did not want to trigger those behaviours. [s. 6. (8)]

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 the care set out in the plan of care is provided to the resident as specified in the plan and that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #009 who requires assistance for meals was positioned safely.

The MOHLTC received complaints related to residents not being fed, poor overall dining experience and staffing issues.

In an observation conducted by Inspector #699 resident #009 was observed to be in bed leaning over the bed rail, eating their meal which was on the bedside table that was positioned at the side of the bed. The head of the bed was position at approximately 45 degrees and there was no staff in the room or in the hallway nearby.

Record review of resident #009's current plan of care indicated that they require a specified level of assistance for eating.

In an interview with RN #114, they stated resident #009 was not positioned safely for their meal. They further stated that the resident should be sitting upright in bed, with the head of bed at a 90 degree angle, with the bedside table across their lap for their meal. RN #114 further indicated that resident #009 typically eats in the dining room, however requested to have their meal in their room for dinner.

In an interview with DOC #101, they stated that resident #009 was not positioned safely for their meal. They indicated that the resident has to be sitting upright with the table across them to ensure safety. [s. 73. (1) 10.]

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 proper techniques are utilized to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

Issued on this 15th day of July, 2019

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

Original report signed by the inspector.