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
Oct 28, 2019	2019_563670_0038	013506-19, 013577-19, 013845-19, 014062-19, 014214-19, 015816-19, 016186-19, 016928-19, 017797-19	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

DEBRA CHURCHER (670), JULIE DALESSANDRO (739), KRISTEN MURRAY (731)

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): October 21, 22, 23 and 24, 2019.

The purpose of this inspection was to inspect the following:
Log# 014062-19 CIS# 0922-000071-19 related to a fall with injury.
Log# 014214-19 CIS# 0922-000072-19 related to a fall with injury.
Log# 013845-19 CIS# 0922-000070-19 related to a fall with injury.
Log# 016186-19 CIS# 0922-000077-19 related to a fall with injury.
Log# 015816-19 CIS# 0922-000076-19 related to a fall with injury.
Log# 013506-19 CIS# 0922-000066-19 related to a resident to resident altercation.
Log# 017797-19 CIS# 0922-000081-19 related to a resident to resident altercation.
Log# 016928-19 CIS# 0922-000079-19 related to a fracture of unknown cause.
Log# 013577-19 CIS# 0922-000067-19 related to a respiratory outbreak.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, one Assistant Director of Care, two Registered Nurses, four Registered Practical Nurses, six Personal Support Workers and one Housekeeping Aide.

During the course of this inspection the inspectors observed the overall cleanliness and maintenance of the facility, observed the provision of care, observed staff to resident interactions, reviewed relevant resident clinical records, reviewed relevant internal investigation records and reviewed relevant policy and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #007 as specified in the plan.

The home submitted a Critical Incident System report (CIS) to the Ministry of Long-Term Care (MOLTC), related to resident #007 experiencing a specific injury.

Review of the amendment to the CIS stated that the investigation was complete and the home had determined that 2 staff members had provided specific care alone and that the care plan indicated two staff were required for the specific care.

Review of the home's internal investigation notes show and interview with Personal Support Worker(PSW) #105 was completed on a specific date. During the interview PSW #105 acknowledged that they had provided specific care to resident #007 without assistance, on a specific date.

The Inspector was unable to locate an interview for PSW #106 but did locate a waiver agreeing to an interview.

Review of resident #007's care plan stated resident #007 required two team members to provide specific care.

An interview was conducted October 22, 2019, with the Director of Care (DOC) #102. DOC #102 stated the home had conducted an investigation into the injury and was unable to determine how the injury had occurred but did determine through the investigation that two PSW's had provided specific care to resident #007 without assistance. DOC #102 was unable to locate the documentation of an interview with PSW #106 but confirmed that PSW #106 had been interviewed on a specific date, and had admitted to providing specific care to resident #007 alone, on a specific cate. DOC #102 stated that all staff denied any injuries or change in the residents condition during interviews but did acknowledge two PSW's did not follow the plan of care.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff on every shift recorded symptoms of infection in residents #008, #009 and #010.

The home submitted a Critical Incident System report (CIS) to the Ministry of Long-Term Care, related to a respiratory outbreak.

Review of the home's internal documentation and the submitted CIS report showed that a respiratory outbreak was declared by Public Health on a specific date, and declared over on a specific date. There was no causative agent isolated.

Review of resident #008's clinical record showed that the resident developed specific symptoms on a specific date, and their symptoms resolved on a specific date. The inspector was unable to locate any documentation related to symptoms of infection for five specific shifts while resident #008 was experiencing symptoms.

Review of resident #009's clinical record showed that the resident developed respiratory symptoms on a specific date, and their symptoms resolved on a specific shift. The inspector was unable to locate any documentation related to symptoms of infection for one specific shift while resident #009 was experiencing symptoms.

Review of resident #010's clinical record showed that the resident developed respiratory symptoms on a specific shift, and the resident was no longer residing at the home on a specific date. The inspector was unable to locate any documentation related to symptoms of infection for one specific shift while resident #010 was experiencing symptoms.

During an interview with Director of Care #102 they stated that resident #008, #009 and #010 were symptomatic. DOC #102 stated that they felt the staff had assessed the residents but did not document the assessments of the symptoms. DOC #102 acknowledged that the symptoms should have been recorded every shift.

The licensee has failed to ensure that staff on every shift record symptoms of infection in residents and take immediate action as required. [s. 229. (5) (b)]

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 on every shift, the symptoms are recorded and that immediate action is taken as required, to be implemented voluntarily.

Issued on this 28th day of October, 2019

[redacted]

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

Original report signed by the inspector.