Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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 20, 2021	2021_779641_0020	010090-20, 011872-20, 017936-20, 024494-20, 007130-21	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

CATHI KERR (641), MANON NIGHBOR (755)

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): June 21, 22, 23, 24, 25, 2021.

This inspection was conducted in reference to intake logs # 010090-20, CIS #0922-000010-20; #011872-20, CIS #0922-000011-20; #007130-21, CIS #0922-000010-21; #024494-20, CIS #0922-000036-20; and #017936-20, CIS #0922-000022-20; related to alleged resident abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Associate Director of Care, the Director of Environmental Services, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Behavioural Support Ontario Nurse, Housekeeping staff, families and residents.

During this inspection the Inspectors completed a tour of the home, observed residents' environments, the provision of care and services to residents, reviewed relevant resident health care records, and policies and procedures related to Zero tolerance of abuse and neglect, Infection Prevention and Control, and Cooling and Air Temperatures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour intervention, Behavioural Support Ontario-Dementia Observation System (BSO-DOS) Data Collection Sheet documentation was complete.

Resident #005 had a history of exhibiting responsive behaviours. On a specified date, a staff member was alerted to resident #002's room and found resident #005 standing near the other resident, who was laying in their bed. It appeared that there had been an altercation between the two residents. The residents were separated and treated for minor injuries.

A BSO-DOS had been initiated for resident #005 earlier that day. During a specified four day period, the BSO-DOS worksheet's column for context was not completed on numerous occasions.

The BSO-DOS Data Collection Sheet, Initials column was indicated by an asterisk, to be a mandatory column to complete.

Staff interviews indicated that it was the expectation that the form was to be completed every half hour, with the PSW being responsible to complete the Observed Behaviour and Context columns and the nurse responsible to initial it.

Sources:
Record review:
Resident Behaviourial Support Ontario-Dementia Observations System (BSO-DOS) Data Collection Sheet and Worksheet.
Interviews:
ADOC #102 and BSO #112 on June 24, 2021.
DOC #101, and PSW #119 on June 25, 2020.

Issued on this 20th day of July, 2021

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

Original report signed by the inspector.