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

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Original Public Report

Report Issue Date: November 04, 2022	
Inspection Number: 2022_1007_0001	
Inspection Type: Critical Incident System	
Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.	
Long Term Care Home and City: Cheltenham Care Community, North York	
Lead Inspector Reji Sivamangalam (739633)	**Inspector Digital Signature** Reji Sivamangalam Digitally signed by Reji Sivamangalam DN: cn=Reji Sivamangalam, o, ou, email=Reji.Sivamangalam@ontario.ca, c=CA Date: 2022.11.07 10:59:40 -05'00'
Additional Inspector(s) Inspector #643 (Adam Dickey) was also present as an assessing mentor during this inspection.	

INSPECTION SUMMARY

The Inspection occurred on the following date(s): October 25-28, 2022

The following intake(s) were inspected:

- Intake #009836-22, Critical Incident System (CIS) #0922-000022-22 related to abuse.

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

- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Reporting and Complaints

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #01 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 20 (a)

The licensee has failed to ensure that a resident could access the resident-staff communication and response system at all times.

The resident was observed lying on the bed in their room, and the call bell cord was on the floor, inaccessible to the resident. The personal Support Worker (PSW) subsequently placed the call bell within the resident's reach.

The PSW verified that earlier, they had not placed the call bell within the resident's reach after transferring the resident to the bed.

Sources: Observations and Interview with the PSW

Date Remedy Implemented: October 26, 2022

WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

NC #02 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to carry out the infection prevention and control (IPAC) audits required by a Minister’s Directive that applied to the long-term care home.

The Minister’s Directive, COVID-19 response measures for long-term care homes directed homes to conduct regular IPAC audits in accordance with the COVID-19 Guidance Document for Long-Term Care Homes in Ontario. The guidance document stated long-term care homes must complete IPAC audits every two weeks unless in outbreak. When a long-term care home is in outbreak, the audits must be completed weekly. At minimum, the audits must include Public Health Ontario's “COVID-19: Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes”.

Rationale and Summary

The home was in a COVID-19 outbreak from July 24 to August 6, 2022. An IPAC audit was not completed during the week of July 24, 2022. Additionally, the home did not conduct the required bi-weekly audits in August 2022, when the home was not in outbreak.

Sources: Home's IPAC audit records, CIS report, Minister's Directive: COVID-19 response measures for long-term care homes, COVID-19 Guidance document for long-term care home in Ontario and interview with the IPAC Lead.

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WRITTEN NOTIFICATION: PREVENTION OF ABUSE AND NEGLECT

NC #03 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to protect a resident from physical abuse by staff.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as " the use of physical force by anyone other than a resident that causes physical injury or pain".

Rationale and Summary

A staff member reported to the home that they had witnessed another staff member physically abusing a resident in the hallway of a home area. The resident was assessed by registered staff and was found to have an injury. The Executive Director verified that the home’s investigation found that the staff member physically abused the resident.

Sources: CIS report, resident’s progress notes and clinical records, interview with staff and Executive Director and home's investigation notes.

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WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC # 04 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The Licensee has failed to ensure that staff provided support for residents to perform hand hygiene prior to receiving meals as required by Additional Requirement, specifically 10. 4 (h), under the Infection Prevention and Control (IPAC) standard.

Rationale and Summary

Residents were observed entering a dining area for lunch, and staff did not provide hand hygiene assistance to the residents before they started eating. A resident verified that the staff did not assist them with hand hygiene before meals. Staff members stated that they did not provide hand hygiene assistance to residents prior to the meal.

The IPAC Lead confirmed that staff were expected to provide hand hygiene assistance to residents when entering the dining room.

Failure to support residents with hand hygiene increased the risk of infection transmission.

Sources: Observations, the home's hand hygiene policy, interview with staff members and IPAC Lead.

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WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC # 05 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure point-of-care signage, indicating enhanced Infection Prevention and Control (IPAC) measures were in place for a resident diagnosed with a transmissible infection as required by Additional Precautions, specifically 9.1 (e) of the IPAC Standard.

Rationale and Summary

A resident was diagnosed with transmissible infection and required point-of-care signage, indicating enhanced IPAC control measures. No point-of-care signage was posted when two staff members provided care to the resident without the required personal protective equipment (PPE).

The Registered Nurse (RN) and IPAC Lead verified that the point-of-care signage, indicating enhanced IPAC control measures, should have been in place for the resident. There was an increased risk of infection transmission when enhanced IPAC control measures were not in place.

Sources: Observations, resident's written plan of care and progress notes, interview with RN and IPAC Lead and home's Additional Precautions policy.

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WRITTEN NOTIFICATION: PREVENTION OF ABUSE AND NEGLECT

NC # 06 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 104 (2)

The licensee has failed to ensure that resident's substitute decision-maker was notified of the result of an investigation of alleged physical abuse by staff.

Rationale and Summary

The home had received a report of witnessed physical abuse of a resident by a staff member and initiated an investigation. They notified the resident's Substitute Decision-Maker (SDM) about the incident but did not notify the SDM of the investigation results.

The Executive Director confirmed that the home did not notify the resident's SDM about the result of the investigation upon its completion.

Sources: The home's investigation notes, the home's prevention of abuse and neglect of resident policy and interview with Executive Director.

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WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC # 07 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 27 (2)

The licensee has failed to report to the Director the results of an investigation into the alleged physical abuse of a resident and the actions taken in response to the incident.

Rationale and Summary

The home received a report of physical abuse of a resident and reported the incident to the Director. The home completed an investigation of the incident but did not report the result of the investigation and the actions taken to the Director.

The Executive Director verified that they did not amend the report to the Director with the result of the investigation and actions taken upon completion.

Sources: CIS report, home's investigation notes, and interview with Executive Director.

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