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
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Original Public Report

Report Issue Date: July 14, 2023
Inspection Number: 2023-1007-0003
Inspection Type: Complaint 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	**Inspector Digital Signature**
Reji Sivamangalam (739633)	Reji K Sivamangalam Digitally signed by Reji K Sivamangalam Date: 2023.07.27 08:04:34 -04'00'

Additional Inspector(s)
Yannis Wong (000707)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 26-29, 2023 and July 4-6, 2023

The inspection occurred offsite on the following date(s): June 30, 2023

The following intake(s) were inspected:

Intake: #00084317 [Critical Incident System (CIS) #0922-000007-23] related to alleged abuse
Intake: #00088928 (CIS #0922-000011-23) related to alleged abuse
Intake: #00090187 (complaint) related to abuse
Intake: #00090240 (CIS #0922-000012-23) related to alleged abuse

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: PREVENTION OF ABUSE AND NEGLECT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

(i) The licensee has failed to ensure that resident #002 was protected from physical abuse by resident #003.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as “the use of physical force by a resident that causes physical injury to another resident.”

Rationale and Summary

A Critical Incident (CI) report was received by the Ministry of Long-Term Care (MLTC) about an incident where resident #002 had a physical altercation with resident #003. Resident #002 sustained injuries due to the altercation.

A staff member stated that they had witnessed resident #002 inside resident #003's room and having a physical altercation with resident #003. Resident #002 sustained skin injuries and required interventions.

The staff member stated that resident #003 said they had physically injured resident #002. Staff members verified that resident #002 was not protected from abuse by resident #003.

Sources: Home’s policy of Prevention of Abuse and Neglect of a Resident, CIS Report, residents’ progress notes and clinical records, interviews with staff members.

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(ii) The licensee has failed to ensure that resident #005 was protected from sexual abuse by resident #004.

Section 2 of the Ontario Regulation 246/22 defines sexual abuse as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member".

Rationale and Summary

A Critical Incident (CI) report was received by the Ministry of Long-Term Care (MLTC) about an incident where resident #004 had touched resident #005 in a sexual manner.

A staff member stated they had witnessed resident #004 touching resident #005 in a sexual manner.

Staff members verified that resident #005 was not protected from abuse by resident #004.

Sources: Home's policy of Prevention of Abuse and Neglect of a Resident, residents' progress notes and clinical records, home's investigation records, interview with staff members.

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WRITTEN NOTIFICATION: PREVENTION OF ABUSE AND NEGLECT

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to comply with the procedure to assess a resident immediately after suspected abuse by another resident per the written policy to promote zero tolerance of abuse and neglect.

In accordance with O. Reg 246/22 s. 11 (1) b, the licensee was required to ensure a written policy to promote zero tolerance of abuse and neglect of residents in place, and the policy must be complied with.

Specifically, staff did not comply with the home's policy when the resident was not assessed immediately following an incident of suspected abuse.

Rationale and Summary

The licensee's policy directed staff to check the resident's condition by assessing the physical well-being immediately after an alleged abuse incident.

A staff member reported an incident of suspected abuse of a resident by another resident to the registered staff members. The head-to-toe-assessment and pain assessment were completed at a later date. The registered staff acknowledged that the head-to-toe and pain assessments were not completed after the incident was reported.

The Director of Care (DOC) confirmed that the registered staff were expected to complete head-to-toe and pain assessments of the resident after the incident was reported.

There was a risk of not identifying the resident's injuries and pain when the assessments were not completed as required.

Sources: Home's policy of Prevention of Abuse and Neglect of a Resident, residents' progress notes and clinical records, home's investigation records, interview with staff members.

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WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

The licensee has failed to ensure that an allegation of abuse of a resident by a staff member that was reported to the licensee was immediately investigated.

Rationale and Summary

The resident alleged that the staff member hit them during care. The registered staff were notified about the incident, and DOC was also notified the same day about the resident's allegation of abuse.

The inspector requested the DOC and Executive Director (ED) to produce the home's investigation notes, and they were unable to provide any notes.

The DOC confirmed that the registered staff had notified them about the resident's allegation of staff to resident physical abuse on the same day of the incident; however, the home did not complete an investigation about the incident.

Failure to immediately investigate the incident of alleged physical abuse of the resident by the staff member could lead to the home's inability to take appropriate actions to protect the resident.

Sources: CIS report; interview with staff members.

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to report the suspected abuse of a resident to the Director immediately after it occurred.

Rationale and Summary

A staff member reported an incident of suspected abuse of a resident by a co-resident to the registered staff.
The incident was not reported to the Infoline-LTC Homes afterhours. The home submitted a Critical Incident System (CIS) report about the incident on the next day.

The DOC acknowledged that the incident was not reported to the Director immediately after it occurred, as required.

Sources: CIS Report, residents' progress notes and clinical records, home's investigation records, interview with staff members.

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WRITTEN NOTIFICATION: Responsive Behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.

The licensee has failed to ensure that a resident had written strategies including techniques and interventions to prevent or minimize identified responsive behaviours.

Rationale and Summary

Staff identified that a resident had responsive behaviours, and there were no written strategies in the plan of care to address these responsive behaviours.

The resident had exhibited responsive behaviors when staff members provided care. At the time of inspection, there were no written strategies in the plan of care about the resident's exhibited responsive behaviours.

The staff member did not usually provide care to the resident and stated they did not know the techniques to use to minimize the resident's behaviors. Staff members stated that the resident would get upset when new staff are providing care and exhibit responsive behaviors if not immediately attended to. Registered staff reviewed the care plan and acknowledged that written strategies for mitigating the identified responsive behaviours were not present but should have been included in the care plan. The DOC confirmed the written strategies should be in the care plan.

Sources: Progress notes; care plan; interviews with staff members.

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WRITTEN NOTIFICATION: Responsive Behaviours

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

The licensee has failed to ensure that actions taken to respond to the needs of residents demonstrating responsive behaviours, including interventions and assessments were documented for a resident.

Rationale and Summary

Specifically, the responsive behaviour intervention, Behavioural Support Ontario-Dementia Observation System (BSO-DOS) Data Collection Sheet documentation and assessment were not completed.

Staff indicated that they initiated BSO-DOS after an incident of alleged staff to resident abuse during care. BSO-DOS is a paper-based tool and documented by direct care staff at a frequency of every half hour. When the BSO-DOS observation is complete, the Behavioural Support Ontario Lead (BSO Lead) completes the BSO assessment by reviewing the observation tool and identifying what may trigger a resident's responsive behaviours.

Staff members initiated the BSO-DOS monitoring for five days immediately after the incident occurred. Review of the BSO-DOS documentation showed missing information for a specific period. After the observation period, the staff member did not complete the BSO assessment.

Staff members stated they did not complete the BSO-DOS documentation on the day of their shifts. The DOC stated the expectation is for staff to document BSO-DOS observation every half hour, with late documentation affecting accuracy. Staff members indicated that the staff should complete the BSO-DOS assessment after the observation period. The DOC stated the expectation is for the staff member to review the observation tool on the next shift.

Failure to document BSO-DOS every half hour and complete the analysis assessment can result in risks, including resident safety, emotional distress, and responsive behaviours not being identified for follow-up.

Sources: Resident's clinical records; interviews with staff members.

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WRITTEN NOTIFICATION: PREVENTION OF ABUSE AND NEGLECT

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (b)

The licensee has failed to notify a resident's substitute decision maker (SDM) within 12 hours upon an incident of suspected abuse.

Rationale and Summary

A staff member reported an incident of suspected abuse of a resident by another resident to the registered staff. The resident did not sustain any injuries. The resident's SDM was not notified of the incident within 12 hours of the occurrence of the incident.

The DOC acknowledged that the home did not notify the SDM about the incident as required.

Sources: Residents' progress notes and clinical records, home's investigation records, interview with staff members.

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