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**
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

# Original Licensee Report

**Report Issue Date:** May 1, 2024

**Inspection Number:** 2024-1007-0001

**Inspection Type:**
Critical Incident

**Licensee:** Vigour Limited Partnership on behalf of Vigour General Partner Inc.

**Long Term Care Home and City:** Cheltenham Community, North York

| **Lead Inspector** | **Inspector Digital Signature** |
|---|---|
| Rajwinder Sehgal (741673) | Rajwinder Sehgal Digitally signed by Rajwinder Sehgal Date: 2024.05.21 13:32:23 -04'00' |

**Additional Inspector(s)**
Ramesh Purushothaman (741150)

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 9, 10, 11, 12, 15, 16, 2024

The following intakes were inspected in the Critical Incident System (CIS) Inspection:

- Intake: #00106613/CI#0922-000003-24 was related to improper transferring of a resident.
- Intake: #00111689/CI#0922-000011-24 was related to fall of a resident
- Intake: #00112172/CI#0922-000014-24 was related to a disease outbreak.
- Intake: #00107509/CI#0922-000005-24 was related to resident-to-resident physical abuse.
- Intake: #00107975/CI#0922-000006-24 was related to physical abuse from staff towards a resident.

The following intakes were completed in the CIS Inspection

- Intake: #00105315/CI# 0922-000049-23 was related to fall of a resident
- Intake: #00106549/CI#0922-000002-24 was related to improper transferring of a resident.

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

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 6 (7)**

Plan of care

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.

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

**Rationale and Summary**

A CIS reported that a resident incurred injuries during provision of care.

According to the resident's care plan, they required a two-person assistance for

specific care. The resident's progress notes indicated that the team member was assisting the resident with their care when the resident began to display verbally and physically responsive behaviors towards staff.

Personal Support Worker (PSW) stated that they had started providing care to the resident by themselves as the resident was calm and compliant with the care. The PSW was aware of the resident's care plan and confirmed care plan instructions were not followed when they assisted the resident.

The Director of Care (DOC) confirmed that the resident required a two-person assistance with specific personal care and acknowledged that the resident's care plan was not followed as required.

There was risk of injury to the resident when their plan of care was not followed.

**Sources:** CIS report, resident's clinical records, interview with PSW, and DOC. [741673]

## WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 28 (1) 2.**
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to immediately report the abuse of a resident that resulted in

harm or a risk of harm to the resident to the Director.

**Rationale and Summary**
A CIS report was submitted by the home related to an incident of physical abuse which occurred between residents #004 and #005.

Resident #005's clinical records indicated that the incident happened on an identified date, when resident #004 caused a physical injury and pain to resident #005.

The DOC acknowledged that the incident was not immediately reported to the Director through the after-hours line when they were first made aware of the incident, however the registered staff were aware of the home's process to contact the after-hours line.

Failure to report an incident of abuse to the director did not place the resident at risk.

**Sources:** CIS, resident #004's and #005's clinical records, interviews with the DOC. [741150]

## WRITTEN NOTIFICATION: Binding on licensees

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 184 (3)**
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee failed to ensure a PSW adhered to the masking policies set out by the

Minister's Directives.

In accordance with the Minister's Directive: COVID -19 response measures for long-term care homes, effective August 30, 2022, and the COVID-19 guidance document for long-term care homes in Ontario, updated March 4, 2024, indicates that staff should consider wearing a mask during prolonged direct resident care defined as one-on-one within two meters of an individual for fifteen minutes or longer.

**Rationale and Summary**
A PSW was observed walking with a resident in their room. They were wearing both face shield and surgical mask; however, the mask wasn't covering their nose. The staff acknowledged that the mask was not covering their nose and they were required to wear the face mask and the face shield properly.

The Infection Prevention and Control (IPAC) lead confirmed that due to an active outbreak on the third floor at the time of observation, all staff on the third floor were required to wear both face mask and face shield and masks should be worn properly and securely covering the nose.

Not wearing a face mask properly increased the risk of infection transmission.

**Sources:** Observation on the third floor; Minister's Directive: COVID-19 response measures for long-term care homes, COVID-19 guidance document for long-term care homes in Ontario; interviews with PSW and IPAC Lead.
[741150]

## WRITTEN NOTIFICATION: Required programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.**
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to comply with their Falls Prevention and Management policy related to Head Injury Routine (HIR).

In accordance with O. Reg. 246/22, s.11 (1) (b), the licensee was required to have a falls prevention and management program that provided strategies to monitor residents and must be complied with.

Specifically, staff did not comply with the home's policy "HIR" which was to be completed as per the schedule on the form. The HIR form directed staff to assess the resident on 14 individual time periods if a head injury was suspected or if the resident fall was un-witnessed.

**Rationale and Summary**
A resident had an unwitnessed fall, and required HIR to be completed.

Review of resident's clinical records indicated HIR was initiated post fall, however HIR assessments were not completed on two of the 14 required assessment times.

The Registered Nurse (RN) indicated that the expectation was to complete all assessments as required and if a resident was asleep, the resident was to be woken up and the assessment conducted. The DOC indicated that it was expected that all scheduled assessments on the HIR record were completed as per the schedule.

They acknowledged that two of the assessments were not completed as per home's policy.

Failure to complete HIR in accordance with home's policy, placed the resident at risk of not being properly assessed for post fall complications.

**Sources:** Review of the home's policy "HIR" # VII-G-30.20 dated March 2024, resident's care plan, progress notes, assessments, interviews with RN, and DOC. [741673]

## WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)**
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee has failed to ensure that the resident's skin alteration was reassessed weekly by registered nursing staff.

**Rationale and Summary**
A resident was found with skin alteration. The resident had an initial head to toe assessment completed by the registered staff, however there were no weekly skin and wound assessments completed on an identified date or any other date until the skin alteration was resolved.

The home's policy titled "Skin & Wound Care Management Protocol" directed registered staff to complete weekly electronic skin and wound assessment using the Point Click Care (PCC) application and the Interactive Personal Application Device (IPAD) until skin alteration was closed/resolved.

The RN and DOC, both stated that the resident's skin alteration should have been assessed weekly using the skin and wound care application and that weekly assessments were not completed.

When the home did not complete weekly assessments of the resident's skin alteration, the resident was at risk for further alteration/deterioration in skin integrity.

**Sources:** Skin & Wound Care Management Protocol Policy VII-G-10.90, last reviewed August 2023, resident's progress notes, care plan, interviews with RN and DOC.
(741673)

## 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) (b)**
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible

The licensee has failed to ensure that when a resident was demonstrating responsive behaviours, the developed strategies were implemented to respond to their behaviours.

**Rationale and Summary**
Resident #002's notes stated that the resident was on 1:1 care due to history of responsive behaviors. On an identified date, a physical altercation occurred between resident #004 and #005. PSW #115 stated that there was no 1:1 staff in resident #004's room at the time of the incident resulting in resident #005 sustaining injuries. PSW #113 acknowledged that they left when their shift ended, leaving resident #004 without 1:1 monitoring. The DOC confirmed that there was no 1:1 monitoring at the time of the incident.

Failing to implement continuous 1:1 monitoring for resident #004 resulted in resident #005 sustaining injuries and pain.

**Sources:** CIS report, clinical records of residents #004 and #005, interviews with PSW #113, #115 and the DOC.
[741150]

## WRITTEN NOTIFICATION: Maintenance services

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 96 (2) (a)**
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

The licensee has failed to ensure that procedures were developed and implemented to ensure that a ceiling lift was kept in good repair, at a level that

meets manufacturer specifications, at a minimum.

**Rationale and Summary**
A CIS report received by the Director indicated that a resident's was injured due to a defect in the ceiling lift.

Interviews with the resident, the Registered Practical Nurse (RPN), the Environmental Service Manager (ESM), and the Maintenance staff revealed that the home had a similar incident in the past where a defect had occurred in the same ceiling lift. After the initial incident, the lift was repaired by the maintenance staff on the same day.

As per ceiling lift Guldmann GH3/GH3+ user manual, "If a defect appears during use of the GH3, stop using the hoist and contact the Guldmann Service Team for repairs". However, the maintenance staff did not contact the vendor for repairs, when the malfunction was discovered the first time. The Executive Director (ED) agreed that the second incident could have been prevented if the repair was completed properly as per the user manual.

There was a moderate impact to the resident related to the ceiling lift not being maintained in good repair.

**Sources:** CIS report # 0922-000003-24, licensee's investigation notes, and interviews with the resident, RPN 3102, ESM #105, maintenance staff #106, and ED #108.
[741150]

## WRITTEN NOTIFICATION: Infection prevention and control program

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 102 (15) 2.**
Infection prevention and control program
s. 102 (15) Subject to subsection (16), every licensee of a long-term care home shall ensure that the infection prevention and control lead designated under this section works regularly in that position on site at the home for the following amount of time per week:
2. In a home with a licensed bed capacity of more than 69 beds but less than 200 beds, at least 26.25 hours per week.

The licensee has failed to ensure that the IPAC lead worked regularly 26.25 hours per week in that position on site at the home with a licensed bed capacity of more than 69 beds but less than 200 beds.

**Rationale and Summary**
The home had a licensed bed capacity of 170 beds, which required an IPAC Lead working on site at the home for a minimum of 26.25 hours per week.

During the inspection, the IPAC lead reported they were scheduled to work onsite 16 hours per week in the role of the IPAC lead. The DOC reported that the IPAC lead started the position in March 2024, and was scheduled to work two days per week until beginning of May 2024, when they would be working full-time in the role. The DOC acknowledged that they were sharing the role and the responsibilities of the IPAC lead in the home for the days when the designated IPAC lead was not working.

Not meeting the minimum required hours for the IPAC Lead may have placed residents at risk of harm if gaps in the home's IPAC program were not identified and addressed.

**Sources:** Review of IPAC lead hours, resident census list; and interviews with IPAC lead and DOC.
[741673]