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 Public Report

Report Issue Date: October 30, 2024

Inspection Number: 2024-1007-0002

Inspection Type:
Complaint
Critical Incident

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

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 29, 30, September 3-6, 9-13, 16-20, 23-26, 2024.

The inspection occurred offsite on the following date(s): September 19, 20, 2024.

The following intakes were completed in this Critical Incident (CI) inspection:
• Intake: #00113377/CI #0922-000018-24, Intake: #00114325/CI #0922-000019-24, Intake: #00118833/CI #0922-000032-24, Intake: #00120016/CI #0922-000038-24, Intake: #00120326/CI #0922-000040-24, Intake: #00122768/CI #0922-000045-24 were related to duty to protect.
• Intake: #00119533/CI #0922-000036-24 was related to falls prevention and management.
• Intake: #00119605/CI #0922-000037-24 was related to infection prevention and control.
• Intake: #00118262/CI #0922-000029-24 was related to injury of unknown cause.
• Intake: #00118829/CI #0922-000033-24 was related to improper care.

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The following intakes were completed in this complaint inspection:
• Intake: #00121829 was related to duty to protect.
• Intake: #00118320 and intake: #00121260 were related to multiple care concerns.

The following intakes were completed in this inspection:
• Intake: #00115564/CI #0922-000020-24, Intake: #00115589/CI #0922-000021-24, Intake: #00116177/CI #0922-000025-24 were related to falls prevention and management, and intake #00113131/CI #0922-000017-24 and Intake: #00116770/CI #0922-000026-24 were related to infections prevention and control.

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

Resident Care and Support Services
Continence Care
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Pain Management
Falls Prevention and Management

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 #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure the implementation of a standard issued by the Director with respect to infection prevention and control (IPAC).

The home has failed to ensure that there were posted signages at entrances and throughout the home in accordance with the "IPAC Standard for Long Term Care Homes September 2023" (IPAC Standard). Specifically, no signs were posted that listed the signs and symptoms of infectious diseases for self-monitoring as well as steps that must be taken if an infectious disease is suspected or confirmed in any individual as required by Additional Screening requirements 11.6 under the IPAC Standard.

Rationale and Summary

On August 29, 2024, there were no posted signages at the entrance and throughout the home that listed the signs and symptoms of infectious diseases for self-

monitoring as well as steps that must be taken if an infectious disease was suspected or confirmed in any individual.

The IPAC Lead acknowledged that signages were not posted and indicated that they later posted signages at the entrance and throughout the home. The required posted signages were observed on September 4, 2024.

Failure to have signages at the entrance and throughout the home that listed the signs and symptoms of infectious diseases for self-monitoring as well as steps that must be taken if an infectious disease was suspected or confirmed in any individual, increased the risk of infection transmission.

Source: Observations; review of "IPAC Standard for Long-Term Care Homes, September 2023"; and interviews with the IPAC Lead, and Director of Care (DOC).

Date Remedy Implemented: September 4, 2024.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident.

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary

The resident's care plan indicated that they required one team member limited assistance for care. Another section of the care plan indicated they required two persons assistance, and the second person was to monitor outside of the resident's room.

A Registered Practical Nurse (RPN) and the DOC both acknowledged that the care plan direction related to the level of assistance the resident required with care was unclear.

Failure to provide clear care directions to staff may lead to inconsistent care for the resident.

Sources: Observation; Resident's care plan; and interviews with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

The licensee has failed to ensure that staff and others involved in different aspects a resident's care, collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

Rationale and Summary

A resident was admitted with a history of a specified health condition and prescribed a treatment as needed.

The treatment was used more frequently after four months as the resident's health condition worsened. Staff documented that the treatment was often not effective. Documentation from the physician showed that the resident was not reassessed for the specified health condition.

A RPN acknowledged that the physician was not notified of the resident's worsening heath condition.

Staff's failure to collaborate with the physician when the treatment for a resident's health condition was ineffective put the resident's health at risk.

Sources: Review of resident's clinical records; and interview with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #004 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 the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary

A resident had a language barrier and required translation tools to communicate their needs and minimize responsive behaviour.

On a specified date, the resident exhibited responsive behaviour during care. The PSW who was providing care indicated that they did not understand the resident.

They acknowledged that they did not use any of the care planned communication tools to communicate with the resident during the incident.

Failure to ensure the care set out in the plan of care for the resident may have impacted their ability to communicate their needs to staff and exacerbated their responsive behaviour.

Sources: Review of resident's clinical records; and interview with staff.

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Specifically, the licensee did not comply with the investigation procedure of their policy.

Rationale and Summary

Two Critical Incident System (CIS) reports were submitted to the Ministry of Long-Term Care (MLTC) related to allegations of physical abuse of a resident by staff.

The home's Prevention of Abuse and Neglect policy directed the Executive Director (ED) or designate to initiate an investigation by requesting that anyone aware of, or

involved in the situation write, sign, and date a statement accurately describing the event.

The DOC acknowledged that there were no staff written statements describing the events. They confirmed that the investigation of the two incidents of alleged abuse were not done in accordance with the licensee's policy.

Failing to ensure that investigations were completed according to the licensee's policy may have impacted the integrity of the home's investigation process.

Sources: CIS Reports, resident's clinical record, the Long-Term Care home's Investigation Package, "Prevention of Abuse and Neglect of a Resident" policy, Vii-G-10.00 (revised October 2023); and interview with the DOC.

WRITTEN NOTIFICATION: Complaints Procedure — Licensee

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

Complaints procedure — licensee

s. 26 (1) Every licensee of a long-term care home shall,

(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure that a written complaint related to a resident's care was immediately forwarded to the Director.

Rationale and Summary

A written complaint was received by the home regarding resident related care concerns. The complaint was not forwarded to the Director.

The DOC acknowledged that the complaint should have been forwarded to the Director.

Sources: Complaint letter; and interview with the DOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #007 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 ensure that a person who had reasonable grounds to suspect abuse of a resident by someone that resulted in harm or risk of harm to the resident immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary

1) An incident of alleged resident to resident abuse occurred on a specified day. A CIS report was submitted to the MLTC approximately eight and a half later the same day. The MLTC after-hour number was not contacted.

The DOC acknowledged that the incident was not immediately reported to the Director.

Sources: Review of CIS; and interview with the DOC.

Rationale and Summary

2) A resident's family member emailed the home's management regarding the suspected abuse of a resident by staff.

The suspicion of abuse was reported to the Director 12 days later.

The DOC acknowledged that the suspicion of abuse of the resident should have been reported to the Director immediately.

Sources: CIS Report; resident's clinical record; and interview with staff.

WRITTEN NOTIFICATION: Doors in a Home

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that doors leading to non-residential areas of the home were kept closed and locked when they were not being supervised by staff.

Rationale and Summary

On September 4, 2024, the doors leading to the four non-residential areas of the home were left unlocked and unsupervised.

A RPN acknowledged that residents were not allowed in any of the areas. They verified that the doors should have been locked when unsupervised.

Failure to secure non-residential areas in the home put residents at risk of accidental injuries.

Sources: Observations; and interview with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
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,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

The licensee has failed to ensure that when a resident exhibited altered skin integrity, they received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument specifically designed for skin and wound assessment.

Rationale and Summary

The home's policy "Skin and Wound Care Management Protocol" directed registered staff to complete the electronic Skin and Wound Assessment using the Point Click Care (PCC) Skin and Wound Application.

A resident's clinical record indicated they had pain and altered skin integrity on a specified date.

A RPN, a Registered Nurse (RN) and the DOC acknowledged that a skin and wound assessment was not completed for the area of skin impairment, and that it should have been completed on the day the area of skin impairment was noted. As a result of the missed initial assessment, one was not completed until 13 days after the skin impairment was identified.

Failure to complete a skin and wound assessment for a resident who exhibited alerted skin integrity minimized the staff's ability to identify and implement interventions to promote healing and manage pain.

Sources: CIS Report, resident's clinical records; home's policy "Skin and Wound Care Management Protocol, VII-G-10.90" 16123469, revised July 2024; interviews with staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure the implementation of a standard issued by the Director with respect to IPAC. The home has failed to ensure proper use of personal protective equipment (PPE), including appropriate application of PPE in accordance with the IPAC Standard as required by Additional Precaution 9.1(d) under the Standard.

Rationale and Summary

Two PSWs were observed entering a room with a resident on droplet and contact precautions. The sequence for the correct application of PPE for donning was to perform hand hygiene (HH), put on gown, put on mask or n95 respirator, put on eye protection, put on gloves. The PSWs were observed to have performed HH, removed their surgical mask and put on a n95 respirator mask, put on eye protection (face shield), performed HH, put on gown, completed HH, put on gloves.

The IPAC Lead and DOC acknowledged that the sequence of the application of PPE used by the PSWs was not appropriate and that the expectation was to follow the sequence outlined above.

Failure to follow the appropriate sequence for application of PPE to care for a resident on droplet and contact precautions increased the risk of infection transmission.

Source: Observations; review of "IPAC Standard for Long-Term Care Homes, September 2023"; PHO's Provincial Infectious Diseases Advisory Committee (PIDAC) Routine Practices and Additional Precautions, November 2012; and interviews with staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (11) (a)

Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,
(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts.

The licensee has failed to ensure that the outbreak management system for detecting, managing, and controlling infectious disease outbreaks was complied with.

In accordance with O. Reg 246/22 s.11. (1) b, the licensee was required to ensure the IPAC program had in place an outbreak management system for detecting, managing, and controlling infectious disease outbreaks and must be complied with.

Specifically, staff did not comply with the licensee's "Reporting of Communicable Diseases and Outbreaks" and "Defining an Outbreak – Respiratory and Enteric" policy, when the home failed to maintain daily communication with the public health unit (PHU) to ensure sharing of test results, when they met the case definition of a confirmed outbreak.

Rationale and Summary

The home's line list indicated that on a specified day two residents exhibited Acute Respiratory Infection (ARI) symptoms with one confirmed case. The home declared an outbreak four days later when the PHU was notified. The home's "Reporting of Communicable Diseases and Outbreaks" policy directed the home to maintain daily

communication with PHU representatives, including completion and sending of line-listing reports, to ensure accurate sharing of disease progression and test results.

The IPAC Lead and DOC indicated that the PHU should have been notified by the home the day they met the case definition of a confirmed outbreak.

Failure of detecting, managing, and controlling infectious disease outbreaks by not sharing test results with PHU when the home met the case definition of a confirmed outbreak, increased the risk of infection transmission.

Source: Review of the home's policy "Defining an Outbreak – Respiratory and Enteric", IX-F-10.00(a), revised April 2024; home's policy "Reporting of Communicable Diseases and Outbreaks", IX-B-10.00, revised April 2024; the home's Line List; and interviews with the IPAC Lead, and DOC.

WRITTEN NOTIFICATION: Notification re Incidents

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 104 (2)

Notification re incidents

s. 104 (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was notified of the result of investigations of alleged physical abuse to the resident.

Rationale and Summary

CIS reports related to alleged abuse of a resident by staff and a co-resident were submitted to the Ministry on two separate dates.

The home also received written complaints from the resident's SDM alleging abuse by staff and a co-resident.

The allegations were investigated by the home, but the SDM was not notified of the results of the investigations.

The DOC confirmed that the home did not notify the resident's SDM of the result of the investigations upon completion.

Failure to communicate the outcome of investigations into alleged abuse of a resident to their SDM was a missed opportunity to be transparent about the home's process and advise the SDM of steps taken by the home to address any identified concerns related to their complaint.

Sources: CIS Reports, the home's investigation notes, correspondence between the home and the resident's SDM; and interview with DOC.

WRITTEN NOTIFICATION: Dealing with Complaints

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that for each complaint received regarding a

resident's care, a response was provided within 10 business days of the receipt of the complaint.

Rationale and Summary

The home received two written complaints alleging abuse of a resident by a co-resident and staff. There were no records of a response to either written complaint.

The home responded to another written complaint about the care of a resident 15 business days after the complaint was received.

The DOC acknowledged that a written response should have been provided to the complainant within 10 business days of the receipt of each complaint.

Sources: Email correspondence between the home and resident's SDM; and interview with the DOC.

WRITTEN NOTIFICATION: Dealing with complaints

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

The licensee has failed to ensure that a written response provided to persons who made a complaint to the licensee concerning resident care included the Ministry's toll-free telephone number for making complaints about homes and its hours of

service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary

1) The home received multiple written complaints from a resident's SDM regarding care concerns to which the home responded in writing.

None of the home's responses included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and the contact information for the patient ombudsman.

The ED acknowledged that the MLTC and patient ombudsman information should have been included in the response letters sent to the complainant.

Failure to provide the MLTC and patient ombudsman information to the complainant may have limited their knowledge of additional avenues to address their concerns related to resident care.

Sources: Review of CIS report and email correspondence between the home and the complainant; and interview with the Executive Director.

Rationale and Summary

2) A resident's family member submitted a written complaint regarding care concerns to the home and the home responded in writing. The response letter did not include the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman.

Failure to provide the MLTC and patient ombudsman information to the complainant may have limited their knowledge of additional avenues to address their concerns related to resident care.

Sources: Review of the complaint letter from a resident's family member; response letter from the DOC; interview with the DOC.

WRITTEN NOTIFICATION: Administration of Drugs

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (2)

Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

A resident was admitted with a history of a specified health condition and prescribed a treatment. The treatment was to be provided when the resident exhibited specific symptoms.

The treatment was not provided 10 separate times over the course of six months when it was required by the resident.

A RPN acknowledged that the treatment should have been provided to the resident when they exhibited specific symptoms for which it was prescribed.

Failure to follow physician's order for the management of the resident's health condition put them at risk of complications.

Sources: Resident's clinical records; and interview with staff.