Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 9, 2017	2016_486653_0012	009723-14	Complaint

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite #200 MARKHAM ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Rockcliffe Care Community
3015 LAWRENCE AVENUE EAST SCARBOROUGH ON M1P 2V7

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ROMELA VILLASPIR (653)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 8 and 9, 2016.

This inspection was initiated from a complaint related to an alleged fall during a transfer.

An identified Critical Incident System (CIS) report was associated with this complaint intake.

During the course of the inspection, the inspector reviewed resident #001's health records, staff schedule, critical incident report, and the home's investigation notes.

During the course of the inspection, the inspector(s) spoke with the Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurse (RN), Physiotherapist (PT), and the Assistant Director of Care (ADOC).

The following Inspection Protocols were used during this inspection:
Falls Prevention
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

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

On an identified date, a complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) regarding an incident wherein resident #001 was allegedly dropped during a transfer.

Interview with the complainant revealed that resident #001 had told the complainant that the resident had fallen while he/she was being transferred by Personal Support Worker (PSW) #100 from wheelchair to bed.

A review of resident #001's written plan of care initiated on an identified date, indicated that resident required extensive level of assistance during transfers, but did not indicate how many staff.

Interviews with PSW #102 and Registered Nurse (RN) #105, revealed that ever since resident #001 was admitted to the home, resident had always required two staff during transfers.

Interview with PSW #100 stated that on an identified date, he/she transferred resident #001 from resident's bed to the wheelchair without assistance. PSW #100 further indicated that resident #001's written plan of care did not provide clear directions as it only indicated extensive level of assistance during transfer, but did not specify how many staff were required to do the transfer.

During an interview, the Assistant Director of Care (ADOC) acknowledged that resident #001's written plan of care did not set out clear directions to staff in regards to the resident's transfer status. [s. 6. (1) (c)]

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

On an identified date, a complaint was received by the MOHLTC regarding an incident wherein resident #001 was allegedly dropped during a transfer.

Interview with the complainant revealed that resident #001 had told the complainant that the resident had fallen while he/she was being transferred by PSW #100 from wheelchair to bed.

A review of resident #001's plan of care revealed the following:
-Written plan of care initiated on an identified date, indicated that resident required extensive level of assistance during transfer, but did not indicate how many staff.
-Centric health assessment on an identified date, completed by the Physiotherapist (PT), indicated that resident required one person during transfer.
-Full Resident Assessment Instrument-Minimum Data Set (RAI-MDS) on an identified date, it was coded under transfer that resident #001's Activities of Daily Living (ADL) self-performance was total dependence, and two-person physical assist was provided during transfers over the entire seven day look back period.

Interviews with PSW #102 and Registered Nurse (RN) #105, revealed that ever since resident #001 was admitted to the home, resident had always required two staff during transfers.

Interview with the PT stated that he/she initially assessed resident #001 upon admission as one person assist for transfers. The PT stated that he/she was not aware that staff were constantly transferring resident #001 with two persons after admission. The PT

further indicated that he/she should have been informed by staff if there were any changes to resident #001's transfer status so that the PT could have re-assessed the resident accordingly.

Interview with PSW #100 stated that on October 27, 2014, he/she transferred resident #001 from resident's bed to the wheelchair without assistance. The PSW stated that extensive level of assistance for transfers meant that resident #001 could be transferred by one or two staff depending on the resident's condition at that time. PSW #100 further indicated that he/she asked resident #001 if resident was okay to transfer with PSW, to which the resident agreed. PSW #100 further indicated that during the transfer, he/she slowly lowered resident #001 to the floor as resident #001's knees became weak and he/she could not weight bear. PSW #100 called for help. PSW #101 and Registered Practical Nurse (RPN) #104 came and the RPN assessed resident #001 and no injuries were noted at that time.

During an interview, the ADOC acknowledged that collaboration did not occur between the interdisciplinary staff in the assessment of resident #001. The ADOC further indicated that if there were any changes regarding the resident's transfer status, the PSWs, registered staff and the PT should have communicated with one another. The ADOC stated that the PT should have been informed of the changes in resident #001's transfer status so that the PT could have reassessed the resident. [s. 6. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident; and that staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

On an identified date, a complaint was received by the MOHLTC regarding an incident wherein resident #001 was allegedly dropped during a transfer.

Interview with the complainant revealed that resident #001 had told the complainant that the resident had fallen while he/she was being transferred by PSW #100 from wheelchair to bed.

A review of resident #001's plan of care revealed the following:
-Written plan of care initiated on an identified date, indicated that resident required extensive level of assistance during transfer, but did not indicate how many staff.
-Full RAI-MDS on an identified date, it was coded under transfer that resident #001's ADL self-performance was total dependence, and two-person physical assist was provided during transfers over the entire seven day look back period.

Interviews with PSW #102 and RN #105, revealed that ever since resident #001 was admitted to the home, resident had always required two staff during transfers.

Interview with PSW #100 stated that on an identified date, he/she transferred resident #001 from resident's bed to the wheelchair without assistance. During an interview, the ADOC acknowledged that it was an unsafe transfer when PSW #100 transferred resident #001 without assistance. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that an improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

Record review of the Critical Incident System (CIS) report submitted by the home on an identified date, to the Director, indicated that the critical incident occurred 33 days prior to the submission of the CIS report. The CIS was initiated related to an alleged fall during a transfer.

Record review of progress notes on an identified date, indicated that resident #001 was sent to hospital at 2215 hours (hrs) due to excruciating pain on an identified body part. An x-ray result from the hospital on an identified date, indicated multiple fractures on an identified body part.

Record review of the home's complaint record on an identified date, indicated that resident #001's Substitute Decision Maker (SDM) complained about the resident's x-ray results from the hospital indicating resident #001 had fractures.

Interview with the ADOC stated that on an identified date, when resident #001 came back from the hospital with the diagnosis of multiple fractures, the resident's SDM had told them that a PSW allegedly dropped resident #001 during a transfer which resulted in a fall and may have caused the fractures. The ADOC further indicated that the home initiated the investigation on an identified date. The ADOC acknowledged that the home did not immediately report the suspicion to the Director when they had reasonable grounds to suspect that improper care of a resident that resulted in harm or a risk of harm, had occurred. [s. 24. (1)]

Issued on this 10th day of February, 2017

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

Original report signed by the inspector.