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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 10, 2019	2019_486653_0008	021688-17, 022577-17	Complaint

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 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): March 12, 13, 14, 15, 18, and 20, 2019.

During the course of the inspection, complaint log #(s): 021688-17, 022577-17 related to allegation of abuse, had been inspected.

During the course of the inspection, the inspector reviewed the home's staffing schedule, the home's investigation notes and complaints binder, resident #001's clinical health records, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Assistant Directors of Care (ADOCs), and the Executive Director (ED).

A Voluntary Plan of Correction related to s. 6 (5) of the Long-Term Care Homes Act, S.O. 2007, identified in concurrent complaint inspection report #(s) 2019_486653_0009 (Log #s 016732-17, 005165-18) and 2019_594746_0008 (Log #s 025973-18, 005570-19) will be issued in this report.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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	Légende 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee had failed to ensure that the resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The following evidence was identified by Inspector #653 under complaint inspection report #2019_486653_0009 (Log #s 016732-17, 005165-18):

The Ministry of Health and Long-Term Care (MOHLTC) ACTIONline received a complaint related to resident #003 sustaining an injury from unknown cause. The complainant reported that the resident was found with an identified injury on an unidentified date and time, and the family was not notified at the time of the incident.

A review of Registered Nurse (RN) #105's progress note revealed on an identified date and time, resident #003 was in front of the nursing station and the RN noted an identified injury on the resident. The RN asked the resident what happened but they stated they did not know.

A telephone interview with RN #105 indicated they were the charge nurse on the identified shift and they had seen resident #003 in front of the nursing station at the time, and found the identified injury. RN #105 called RN #138 who worked the shift prior to ask if they had noticed the injuries before, and RN #138 indicated the injuries were old.

The inspector attempted to interview RN #138 however, they were unavailable for an interview.

A review of resident #003's progress notes and the assessments on Point Click Care (PCC) did not identify documentation indicating the Substitute Decision-Maker (SDM) had been notified of the resident's injuries when they were first noted by staff.

During an interview, Assistant Director of Care (ADOC) #116 acknowledged there was no documentation indicating resident #003's SDM had been notified of the injuries when it was first noted by staff. The ADOC further indicated the home's expectation was for the registered staff to notify the resident's SDM once they had first noted the injuries. [s. 6. (5)]

2. The following evidence was identified by Inspector #746 under complaint inspection report #2019_594746_0008 (Log #s 025973-18, 005570-19):

The MOHLTC received a complaint related to the home not informing the SDM of an alteration in skin integrity related to resident #014.

A telephone interview with the complainant indicated that the home did not inform the family of an alteration in skin integrity which resident #014 sustained on an identified date. The complainant indicated that from past experiences when resident #014 sustained any form of alteration in skin integrity, the SDM was informed.

The complainant indicated that when resident #014's family visited the home on an identified date, they noticed an alteration in skin integrity to resident #014's identified part of the body. The family member was upset that the staff had been aware of this alteration in skin integrity and no one had contacted them. The complainant indicated the family had sent a letter to the Executive Director (ED), asking why the family was not notified. Resident #014's family member received a letter from the ADOC responding to their concern. A review of the response letter to the family completed by ADOC #129 indicated that an in-service was carried out by the care community related to registered staff informing family about alteration in skin integrity.

The complainant further indicated that on an identified date, a similar incident occurred wherein resident #014's family member came to visit the resident and identified an alteration in skin integrity to resident #014's identified part of the body. The family member was not called by the home.

A review of the progress notes revealed the resident had been identified with an alteration in skin integrity on an identified date. Further review of the progress notes for the above noted alteration in skin integrity did not include any mention of having informed the family.

During an interview, RN #140 stated that the expectation was to inform the family of any altered skin impairment. RN #140 indicated they had forgotten to call the family when they had first noted the alteration in skin integrity. RN #140 further indicated the family was not informed about resident #014's alteration in skin integrity on two different occasions.

During interviews with ADOC #129 and ADOC #130, they indicated that family were to be informed when new alteration in skin integrity was identified.

ADOC #129 acknowledged that the registered staff should have informed the family of

the alteration in skin integrity.

The licensee had failed to ensure that the residents' SDMs were given an opportunity to participate fully in the development and implementation of the residents' plan of care. [s. 6. (5)]

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 the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

Issued on this 10th day of May, 2019

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

Original report signed by the inspector.