Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 31, 2019	2019_685648_0018 (A2)	005627-18, 015716-18, 023200-18, 025516-18, 026610-18, 030186-18, 030336-18, 002310-19, 005359-19, 008177-19, 009731-19, 012585-19, 013559-19, 015653-19	Critical Incident System

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

Amended by JOVAIRIA AWAN (648) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Health and Long-Term Care

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

Attn: Nazira Jaffer, Administrator,
Rockcliffe Care Community

Please find enclosed a revised inspection and order report related to Critical Incident System (CIS) inspection #2019_685648_0018.

Issued on this 31st day of October, 2019 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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3015 Lawrence Avenue East SCARBOROUGH ON M1P 2V7

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

Amended by JOVAIRIA AWAN (648) - (A2)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 27, 28, 29, 30, September 4, 5, 6, 9, 10, 11, 12, 13, 16, 17, 18, 19, 20, 23, 24, 25, 26, 2019

During the course of the inspection, the following intakes were reviewed:

Log# 026610-18, related to unexpected death

Log# 025516-18, related to a missing resident with injury

Log# 030186-18, related to fracture of unknown cause

Log# 005627-18, related an allegation of abuse

Log# 023200-18, related to skin and wound management, and an allegation of neglect

Log# 015716-18, related to unsafe transfer

Log# 030336-18, related to unsafe transfer

Log# 015653-19, related to maintenance and accommodations

Log# 008268-19, related to nutrition and hydration and an allegation of neglect

Log# 012585-19, related to injury of unknown cause

Log# 002353-19, related to unknown bruising of skin and discharge

Log# 013559-19, related to maintenance and accommodations

Log# 002310-19, related to suspected fall with injury

Log# 010238-19, related to skin and wound management and an allegation of neglect

Log# 005359-19, related to hospitalization

Log# 008177-19, related to maintenance and accommodations

Log #009731-19 for Compliance Order #001 related to s. 6 (7), issued under report #2019_486653_0010 with a compliance due date of July 26, 2019.

During the course of the inspection, the inspector(s) conducted observations of medication administration pass times, staff and resident interactions, record review of health records, staffing schedules, home's investigation record, and relevant policies and procedures.

During this inspection the following inspections were conducted concurrently:

Complaint Report #2019_685648_0017,

Complaint Report #2019_807644_0013

Inspector Asal Fouladgar, #751, was on-site training during this inspection September 4 to 13, 2019.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Registered Dietitian (RD), Physiotherapist (PT), Recreation

Assistant (RA), Director of Resident Programs (DRP), Director of Environmental Services (DES), Maintenance Technician (MT), Housekeeping Deep Cleaners (HDC), Assistant Director of Care (ADOC), Director of Care (DOC), Executive Director (ED), and Central East Local Health Integration Network Senior Manager (CELHIN SM)

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Admission and Discharge
Hospitalization and Change in Condition
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.

8 WN(s)
4 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2019_486653_0010	648

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 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 techniques when assisting residents.

The home contacted the Ministry of Long-Term Care (MLTC) after hours pager on an identified date, and submitted a Critical Incident System (CIS) two days later, to the MLTC Director. The CIS report indicated an incident had occurred which resulted in resident #022 sustaining an injury. The CIS further indicated at the time of the incident, the resident complained of pain. The home ordered a

diagnostic test and medication as needed (PRN), which was offered to and refused by the resident. The family was informed and agreed to transfer the resident to hospital for further assessment.The resident returned to the home the following day with treatment and discharge notes stating the resident was found to have an injury.

A review of resident #022's progress notes indicated the resident resided on an identified home area prior to discharge.

A review of the resident's plan of care at the time of the incident was carried out. The plan of care directed staff to transfer the resident in an identified manner using specified transfer equipment.

A review of the home's schedule was carried out for the week of the incident, which indicated the primary day Personal Support Worker (PSW) staff as PSW #157 and PSW #149 as the primary night PSW.

PSW #157 was unable to be reached for a telephone interview.

Separate interviews were carried out with PSW #149, Registered Practical Nurse (RPN) #154, and Registered Nurse (RN) #156. The staff indicated they worked full-time on resident #022's home area during the week of the incident, and stated they were aware of resident #022 and thier needs. The staff indicated that the resident required a specified level of assistance for all Activities of Daily Living (ADL's) and specific transfer equipment, as indicated on the plan of care. The staff indicated they recall an incident which occurred involving resident #022 who was found to have an identified injury and heard the resident was transferred independently by PSW #157. The staff stated the home carried out an investigation. The staff further stated if a staff did not provide transfers to residents who required it in a specified manner with appropriate transfer equipment, according to the homes policy, they would be placing the resident at risk for a fall and/or injury,

An interview was carried out with Associate Director of Care (ADOC) #139, who indicated they submitted the above CIS report to the MLTC Director. The ADOC stated they met with resident #022's family after the incident. The family reported they had observed several occasions of PSW #157, providing resident #002 transfer assistance which was not consistent with the manner in which they required and also had observed the roommate resident #027, to assist the PSW

with the transfers. The ADOC stated as their investigation was ongoing, they had new information and interviewed resident #027, with the Director of Care (DOC). The ADOC stated resident #027's cognition demonstrated awareness of their surroundings and they demonstrated use of transfer equipment which was used to assist PSW #157 when providing assistance to resident #022. The ADOC acknowledged the home had two statements and observations from family and co-resident of PSW #157, carrying out transfers for resident #022 inconsistent with the manner in which they required. [s. 36.]

2. The home submitted a CIS report an identified date to the MLTC Director indicating an incident had occurred causing an injury to a resident for which the resident was taken to hospital. The CIS report further stated prior to the incident report, resident #026 complained of persistent pain and the family requested to transfer the resident to hospital for further evaluation and assessment. The resident stated they injured the area of identified pain during the provision of care. The resident returned to the Long-Term Care (LTC) home with an identified injury and treatment in place for a specified period of time.

A review of resident #026's plan of care identified the resident required care in an identified manner with specified transfer equipment for transfers and continence care.

An interview was carried out with resident #026 who stated they recall the above incident when they sustained the injury. The resident stated that PSW #141 and another staff who was not regular at the home moved the resident for care without their usual transfer equipment and in a manner inconsistent with their identified plan of care, and were subsequently injured during this process. The resident stated they informed the PSW of this and also RN #136 of the incident and pain which they identified at the site of the injury. The resident stated the home spoke to them about the incident.

An interview was carried out with PSW #141, who stated they where aware of the above incident involving resident #026. The PSW stated that on the date of the incident, the resident had informed the home that during the transfer with the PSW the resident sustained an injury. The PSW stated they had assistance from an agency staff, and they did not utilize the specified transfer equipment for resident #026 and provided transfer in a manner inconsistent with the plan of care. The PSW staff stated they were unable to recall the residents transfer status during this time.

An interview was carried out with ADOC #105, who stated staff are to always complete all transfers of residents including the use of transfer equipment in a safe manner. The CIS report, staff and resident interviews, and resident #026's plan of care were reviewed with the ADOC. The ADOC acknowledged that the staff did not practice safe transferring techniques for resident #026. [s. 36.]

3. The MLTC received a Critical Incident on an identified date, related to an injury sustained to resident #008 while being repositioned by PSW staff in their PASD. The resident was transferred to hospital for further assessment. The resident returned from hospital on the same day with a diagnosis for and treatment of an identified injury.

A review of resident #008's written plan of care, indicated the resident required an identified level of assistance for repositioning.

A review of progress notes related to the incident identified the resident was in a home area when PSW #165 repositioned the resident in their PASD. An injury was identified at this time and the resident was sent to hospital for further assessment. Resident returned to the home from hospital on the same day with a diagnosis and treatment of the identified injury.

An interview with Registered Practical Nurse (RPN) #144 indicated that it was the home's expectation that the PSWs explain what they are going to be doing prior to care. They further indicated PSW #165 was not careful when repositioning resident #008 in their PASD.

An interview with PSW #165 confirmed they had attempted to reposition resident #008 in their PASD at the time of the incident. They further indicated they did not notice the resident's position prior to repositioning. The PSW #165 acknowledged they did not perform safe positioning techniques when they repositioned resident #008.

A review of the home's investigation notes was carried out related to the above incident which occurred involving resident #008. The investigation notes indicated that camera footage was reviewed at the time of the incident which revealed that PSW #165 approached resident #008 without looking at the resident prior to positioning their PASD resulting in injury. Camera footage of the incident was unavailable for review by the inspector.

An interview was conducted with ADOC #139 related to the identified incident which involved PSW #165 and resident #008. The ADOC #139 indicated that PSW #165 did not safely reposition resident #008 according to the home's expectation as a trained staff member.

The ADOC #139 acknowledged the PSW did not use safe positioning technique when assisting to reposition the resident.

The severity of this issue was determined to be a level 3 as actual harm occurred to residents causing injury. The scope of the issue was 3 as it related to three of the three residents reviewed. The home had a level 3 history as they had previous non compliance related to a same subsection.
- Voluntary Plan of Correction (VPC) issued February 9, 2017 (2016_486653_00128);
- VPC issued March 23, 2019 (2019_594746_000). [s. 36.] (644) [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where this Act or this Regulation requires the licensee to a long-tern care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with.

In accordance with O. Reg 79/10, s. 90 (1), which states an organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, there are schedules and procedures in place for routine, preventive and remedial maintenance.

A review of the home's policy "Preventative Maintenance Program" (policy # V-C-10, January 2015, and revised March 2019) indicated the following under the procedures:
1) The Environmental Services Manager or designate is responsible for coordinating and overseeing the Preventative Maintenance Program. This includes ensuring the routine audit and implementation of a system for inspecting, testing and checking (task as applicable by item/system) of equipment and building systems for proper functioning to ensure the safety of residents, team members, and visitors to the community/residence.
3) Remedial measures will be implemented and completed in a timely, efficient, and effective manner.
4) All repair work completed as a result of preventative audits or reported "work orders" will be documented by Maintenance team member and tracked by the Environmental Services Manager or designate.

The MLTC, ACTIONline received a complaint on an identified date related to black mold all over the building, no sprinkler system, bath tubs not hooked to plumbing, both elevators constantly breaking down, short staffed, no proper

equipment for colostomy care. The complainant was not available to be interviewed by the inspector.

Inspector #644 and #648 observed black mold-like substances on several different care areas in the home during the course of this inspection.

Inspector #644 contacted LTC Homes Consultant and Environmental Inspector #120 regarding the observations made of the walls in the shower rooms of the home. Photographs were also taken and shared with Inspector #120. Based on Inspector #644's observations, photos, location and conditions described in the shower area, the black coloured substance appeared to resemble mould.

Inspector #644 made observations during the course of the inspection on several different home areas which revealed that the shower vents were soiled as well as heavy dust was also noted.

Observation conducted during the inspection revealed the black coloured substance that appeared to resemble mould and ceiling deficiencies on a specified shower room reported in February 2019 and observed by the inspector August 28, 2019, were repaired on the weekend of August 31, 2019 at the time of this inspection. Inspector further observed all shower room vents were clean.

Housekeeping Lead (HL) #123 and Director of Environmental Services (DES) #119 were unable to provide to the inspector completed preventative audits of the shower rooms for 2018 and for six months in 2019 at the time of this inspection.

Interview with housekeeper #107 indicated they are assigned audits in 2018 and 2019 to be completed but did not do them. They further stated that the black coloured substance that appeared to resemble mould and ceiling deficiencies were verbally reported to the DES #119, maintenance staff #114 and did not recall when it was reported.

Interview with maintenance staff #114 indicated when they had completed the remedial maintenance repairs of the specified unit's shower room ceiling and the monthly cleaning of the shower room vents they did not document the date the repairs and preventative maintenance were completed.

Interview with HL #123 indicated they had assumed the role of Housekeeping Lead February 2019 and had no completed monthly audits from the home's

managers for the shower rooms except for the month of February and June 2019. HL #123 further stated that when the Common Area Cleaning Audit Form was completed with no specific date identified in February 2019, that the noted deficiencies of the black coloured substance and ceiling deficiencies were discussed for repair with DES#119 and the previous ED.

Interview with DES #119 indicated that they were not aware of the black coloured substance in the specified unit's shower room, had no records of audits completed of the shower rooms in 2018, no records of when the shower room vents were cleaned and preventative checks in 2018, including 2019, and no records of remedial repairs completed in 2018 and 2019 for the shower rooms. They further stated when remedial repairs are completed maintenance staff #114 does not document the repairs when completed and did not have a specific date the ceiling repairs were completed in the specified unit's shower room.

Interview with the Executive Director #137 acknowledged that the staff did not follow the home's policy related to Preventative Maintenance Program specifically audits of the shower rooms were not completed in 2018 and for six months at the time of this inspection for 2019, no records of when repair work and preventative maintenance was completed.

The home failed to ensure any policy or system instituted or otherwise put in place was complied with. [s. 8. (1) (b)]

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 where this Act or this Regulation requires the licensee to a long-tern care home to have, institute or otherwise put in place any policy, that policy is complied with,, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, 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. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy that promotes zero tolerance of abuse and neglect of residents was complied.

The home's policy "Preventions of Abuse and Neglect of Resident", policy #VII-G-10.00 with a current revision date of January 2015, under policy it directs all employees, volunteers, agency staff, private duty caregivers, contracted service providers, residents, and families are required to immediately report any suspected or known incidents of abuse or neglect of the Director of Ministry of Health and Long-Term Care (MOLTC) and the Executive Director/Administrator or designate in charge of the home.

The home submitted a CIS report on an identified date, to the MLTC Director alleging an interaction of inappropriate behaviour had occured with two residents in an identified home area. The CIS stated registered staff had documented resident #023 was observed expressing an inappropriate behaviour with a co-resident in close proximity. The amended CIS indicated surveillance camera footage was reviewed and it was noticed resident #023 expressed an inappropriate behaviour towards resident #024. No witnesses were noted to be in the area.

Review of resident #023's progress notes dated prior to the reported CIS, identified a separate incident related resident #023 expressing inappropriate behaviour towads another resident in a specified area of the home. As per the note documented by Recreation Assistant (RA) #158, they observed the interaction between resident #023 and the other resident. RA #158 informed the charge nurse immediately and both residents were separated from each other with the assistance of PSW staff as per the documented progress note. The

progress note further indicated resident #023's inappropriate behaviour continued even after they were asked to stop.

The Inspector reviewed the home's 2018 CIS binder and was unable to find a CIS report or investigation note related to the above documented incident.

An interview was carried out with ADOC #105, who stated if staff witness alleged abuse of any type or neglect the staff are to separate the abuser from the victim, keep them separated, report to the registered staff, and then to the homes designated ADOC's. The ADOC and the Inspector reviewed resident #023's progress note during the interview. The ADOC stated that they where unaware of the incident as it was not reported to them by the staff. The ADOC acknowledged staff witnessing the alleged abuse did not follow the home's policy to ensure that abuse was reported. [s. 20. (1)]

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 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds where assessed by a registered dietitian who was a member of the staff of the home.

The home submitted a CIS on an identified date to the MLTC Director indicating staff to resident neglect had occurred. The CIS report indicated that resident #025 was being closely monitored for skin imparity. The residents area of skin imparity was assessed on an identified date, followed by a subsequent assessment by the Enterostomal (ET) nurse, and new recommendations to the treatment for the skin imparity were made. Following this assessment, resident #025's skin status deteriorated further and treatment was organized accordingly.

Separate interviews where carried out with RN #148 and ADOC #139 who indicated when a skin alteration is noted a Dietitian referral is carried out on PCC assessments and the resident would be assessed with in the week. The RN and ADOC reviewed the PCC assessments and acknowledged that a Dietitian referral was not sent when resident #025's skin imparity was initially identified and the resident was not immediately assessed. [s. 50. (2) (b) (iii)]

2. The licensee has failed to ensure that when a resident exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, the

resident was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A review of resident #025's health records indicated the resident had identified areas of skin imparity. Review of the residents health record identified multiple instances of missing "Weekly Skin Assessments" for the identified areas of skin imparity. Diagnostic results during the period reviewed identified deterioration in the status of the skin imparity and treatment was subsequently organized.

An interview was carried out with the ADOC#139 who managed the Skin and Wound program and oversaw the program with the lead (unavailable during the inspection period). The ADOC stated the home's policy directed staff to carryout a skin assessment on admission, return from leave of absence (LOA) for more than 24 hours (hrs), return from hospital, a change in skin condition. The ADOC stated a weekly skin assessment was to be initiated if alteration in skin integrity is noted. Inspector reviewed the above CIS report and resident #025's health record with the ADOC. The ADOC stated they submitted the report as staff to resident neglect had occurred related to resident #025's areas of skin imparity which where not assessed on a weekly basis. The ADOC acknowledged the home did not complete weekly skin assessments as required and the residents skin imparity deteriorated. The ADOC further stated the home did not protect resident #025 from neglect as the home was aware of areas of skin imparity and should have monitored the resident. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director is immediately informed, in as much detail as possible in the circumstances, of a resident who is missing for three hours or more.

The MLTC received on an identified date reporting resident #034 was last seen in the home since the day prior to the report made to the Director.

Review of resident #034's progress notes documented by registered staff and physiotherapy during the period identified in the CIS indicated the resident could not be located by the homes staff across multiple shifts. Oncoming staff were informed that the resident was not in the home and could not be reached. The home was made aware of resident #034's whereabouts by the police informing them that the resident was admitted to hospital with injury the following day.

RPN #167 was unavailable to be interviewed at the time of this inspection.

An interview was completed with the full time day shift registered staff for resident #034's home area, RN #146. RN #146, identified staff are to immediately initiate a code yellow and report to management, ministry, and the police, when a resident is missing from the home for a period greater than three hours. RN #146 stated they were familiar with resident #034's daily routine.

An interview with the homes DOC was conducted related to resident #034 and the CIS as noted. The DOC stated that resident #034 was known to leave the home on LOA, and would typically return to the home the same day. Review of residents #034 progress notes was conducted with the DOC. The DOC acknowledged that staff were unable to locate the residents whereabouts during the identified shift, and resident #034 would have been considered missing at this time. The DOC stated that staff for the following two shifts, failed to inform the Director immediately despite being aware that resident #034 was missing from the home for more than three hours. The DOC stated disciplinary action had been taken with staff identified for failing to report upon becoming aware. The DOC acknowledged the home failed to inform the Director immediately, when resident #034 was missing for more than three hours. [s. 107. (1) 3.]

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 Director is immediately informed, in as much detail as possible in the circumstances, of a resident who is missing for three hours or more, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee had failed to protect the resident from sexual abuse by anyone.

The home submitted a CIS report on an identified date, to the MLTC Director alleging an interaction of inappropriate behaviour had occured with two residents in an identified home area. The CIS stated registered staff had documented resident #023 was observed expressing an inappropriate behaviour with a co-resident in close proximity. The amended CIS indicated surveillance camera footage was reviewed and it was noticed resident #023 expressed an inappropriate behaviour towards resident #024. No witnesses were noted to be in the area.

A review of resident #023's health records identified mild cognitive impairment and multiple instances of inappropriate behaviour expressed in common home areas with close proximity and interaction with co-residents in the home. Progress notes identified resident #023 was not easily redirected when they exhibited the inappropriate behaviour. A review of the residents plans of care dated over a period of time, did not show evidence of the home ensuring measures were put into place to keep vulnerable residents safe from resident #023's inappriopriate

behaviours.

A review of resident #024's health records identified cognitive impairment and did not identify inappropriate behaviours.

Inspector #604 reviewed the home surveillance footage for the date of the alleged incident. Resident #023 was observed by PSW #148 to interact with resident #024 in an inappropriate manner. The PSW then called RAIC #127. In the camera footage it was noted resident #024 was sitting in an identified area of the home in close proximity to resident #023. Once observed the RAIC moved resident #024 but not further away from resident #023. The PSW and RAIC staff was then seen leaving the area, leaving resident #023 and #024 in the the home area with no further actions.

Separate interviews where carried out with ADOC #105, PSW #148 and the RAIC #127. The staff indicated the home's expectation was when an incident of alleged abuse occurs the two residents are to be separated and taken out of the area. The staff indicated resident #023 was cognitively aware of their actions whereas resident #024 presented with cognitive decline. During the interview, PSW #148 stated they had been away on leave and were unable to recall the full events of that day. The RAIC and ADOC reviewed the above surveillance footage with the Inspector separately and identified themselves and PSW #148 who was seen on the surveillance footage. The RAIC and ADOC stated the home was aware of resident #023's inappropriate behaviours. The RAIC and ADOC stated that they should have moved resident #023 or #024 out of the home area as leaving both residents where they where could have led to another incident between the two residents.

In separate interviews carried out with AA #125, RN #126, RAIC #127, PSW #151, and ADOC #105, the staff reviewed the above two plans of care for resident #023. The staff acknowledged the resident #023's plan of care did not identify their inappropriate behaviour did not provide staff with clear direction. The staff indicated resident #024 had cognitive decline and could not give consent and recognized the incident which occurred on the identified date as abuse by resident #023 which could have been prevented. The staff further stated resident #024 was not protected from abuse. [s. 19. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident which included any identified responsive behaviours.

The home submitted a CIS report on an identified date, to the MLTC Director alleging an interaction of inappropriate behaviour had occured with two residents in an identified home area. The CIS stated registered staff had documented resident #023 was observed expressing an inappropriate behaviour with a co-resident in close proximity. The amended CIS indicated surveillance camera footage was reviewed and it was noticed resident #023 expressed an inappropriate behaviour towards resident #024. No witnesses were noted to be in the area.

A review of resident #023's health records identified multiple instances of the resident expressing inappropriate behaviours with interactions and in close proximity of co-residents.

A review of resident #023's plans of care over an extended period of time did not identify inappropriate behaviour documented in their progress notes.

An interview carried out with Activation Aide (AA) #125, who stated they documented on an identified date, their observation of resident #023 presenting with inappropriate behaviours in a home area while close proximity of resident #027. The AA stated the staff in the home were aware of resident #023's

inappropriate behaviours. The AA reviewed the above plans of care and acknowledged the plans of care did not identify inappropriate behaviours presented by resident #023.

Separate interviews carried out with RN #126, Resident Assessment Instrument (RAI) Coordinator #127, and PSW #151. The staff indicated staff in the home would refer to the resident plan of care to gather information related to all aspects of the resident. The staff stated they were aware of resident #023 who presented with inappropriate behaviours. The staff reviewed the above plans of care and acknowledged that the plans of care did not identify the inappropriate behaviours which the resident presented and there were no interventions identified.

An interview was carried out with the ADOC #105. The ADOC stated that they are aware of resident #023's inappropriate behaviours over an identified period of time. The ADOC reviewed the above plans of care and acknowledged the plans of care did not identify the inappropriate behaviours presented by resident #023 which the home was aware off. [s. 26. (3) 5.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse.

The home submitted a CIS report on an identified date, to the MLTC Director alleging an interaction of inappropriate behaviour had occured with two residents in an identified home area. The CIS stated registered staff had documented resident #023 was observed expressing an inappropriate behaviour with a co-resident in close proximity. The amended CIS indicated surveillance camera footage was reviewed and it was noticed resident #023 expressed an inappropriate behaviour towards resident #024. No witnesses were noted to be in the area

An interview was carried out with ADOC #105, who indicated they submitted the CIS report, involving resident #023 who was observed exhibiting an inappropriate behaviour while interacting with resident #024 and reported the incident as alleged abuse to the MLTC Director. The ADOC stated the home would contact the police with any allegation of abuse and would also initiate their investigation. The ADOC further stated the home did not call the police for the above incident and should have contact the police as it was an allegation of identified abuse. [s. 98.]

Issued on this 31st day of October, 2019 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

Amended Public Copy/Copie modifiée du public

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JOVAIRIA AWAN (648) - (A2)
Inspection No. / No de l'inspection :	2019_685648_0018 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	005627-18, 015716-18, 023200-18, 025516-18, 026610-18, 030186-18, 030336-18, 002310-19, 005359-19, 008177-19, 009731-19, 012585-19, 013559-19, 015653-19 (A2)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 31, 2019(A2)
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Rockcliffe Care Community 3015 Lawrence Avenue East, SCARBOROUGH, ON, M1P-2V7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Nazira Jaffer

To Vigour Limited Partnership on behalf of Vigour General Partner Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10. s 36.

Specifically, the licensee shall ensure that:
a) Residents #026 and #008, and all residents who require staff assistance with transfers, are provided with safe transferring and positioning techniques.

b) Must ensure that only trained staff participate in lifts and transfers.

Grounds / Motifs :

1. The home submitted a CIS report an identified date to the MLTC Director indicating an incident had occurred causing an injury to a resident for which the resident was taken to hospital. The CIS report further stated prior to the incident report, resident #026 complained of persistent pain and the family requested to transfer the resident to hospital for further evaluation and assessment. The resident stated they injured the area of identified pain during the provision of care. The resident returned to the Long-Term Care (LTC) home with an identified injury and treatment in place for a specified period of time.

A review of resident #026's plan of care identified the resident required care in an identified manner with specified transfer equipment for transfers and continence care.

An interview was carried out with resident #026 who stated they recall the above incident when they sustained the injury. The resident stated that PSW #141 and another staff who was not regular at the home moved the resident for care without their usual transfer equipment and in a manner inconsistent with their identified plan of care, and were subsequently injured during this process. The resident stated they informed the PSW of this and also RN #136 of the incident and pain which they identified at the site of the injury. The resident stated the home spoke to them about the incident.

An interview was carried out with PSW #141, who stated they where aware of the above incident involving resident #026. The PSW stated that on the date of the incident, the resident had informed the home that during the transfer with the PSW the resident sustained an injury. The PSW stated they had assistance from an agency staff, and they did not utilize the specified transfer equipment for resident #026 and provided transfer in a manner inconsistent with the plan of care. The PSW staff stated they were unable to recall the residents transfer status during this time.

An interview was carried out with ADOC #105, who stated staff are to always complete all transfers of residents including the use of transfer equipment in a safe manner. The CIS report, staff and resident interviews, and resident #026's plan of care were reviewed with the ADOC. The ADOC acknowledged that the staff did not practice safe transferring techniques for resident #026. (604)

2. The home submitted a CIS report an identified date to the MLTC Director indicating an incident had occurred causing an injury to a resident for which the resident was taken to hospital. The CIS report further stated prior to the incident report, resident #026 complained of persistent pain and the family requested to transfer the resident to hospital for further evaluation and assessment. The resident stated they injured the area of identified pain during the provision of care. The resident returned to the Long-Term Care (LTC) home with an identified injury and treatment in place for a specified period of time.

A review of resident #026's plan of care identified the resident required care in an identified manner with specified transfer equipment for transfers and continence care.

An interview was carried out with resident #026 who stated they recall the above incident when they sustained the injury. The resident stated that PSW #141 and another staff who was not regular at the home moved the resident for care without their usual transfer equipment and in a manner inconsistent with their identified plan of care, and were subsequently injured during this process. The resident stated they informed the PSW of this and also RN #136 of the incident and pain which they identified at the site of the injury. The resident stated the home spoke to them about the incident.

An interview was carried out with PSW #141, who stated they where aware of the above incident involving resident #026. The PSW stated that on the date of the incident, the resident had informed the home that during the transfer with the PSW the resident sustained an injury. The PSW stated they had assistance from an agency staff, and they did not utilize the specified transfer equipment for resident #026 and provided transfer in a manner inconsistent with the plan of care. The PSW staff stated they were unable to recall the residents transfer status during this time.

An interview was carried out with ADOC #105, who stated staff are to always complete all transfers of residents including the use of transfer equipment in a safe manner. The CIS report, staff and resident interviews, and resident #026's plan of care were reviewed with the ADOC. The ADOC acknowledged that the staff did not practice safe transferring techniques for resident #026. (604)

3. The home submitted a CIS report an identified date to the MLTC Director indicating an incident had occurred causing an injury to a resident for which the resident was taken to hospital. The CIS report further stated prior to the incident report, resident #026 complained of persistent pain and the family requested to transfer the resident to hospital for further evaluation and assessment. The resident stated they injured the area of identified pain during the provision of care. The resident returned to the Long-Term Care (LTC) home with an identified injury and treatment in place for a specified period of time.

A review of resident #026's plan of care identified the resident required care in an identified manner with specified transfer equipment for transfers and continence care.

An interview was carried out with resident #026 who stated they recall the above incident when they sustained the injury. The resident stated that PSW #141 and another staff who was not regular at the home moved the resident for care without their usual transfer equipment and in a manner inconsistent with their identified plan of care, and were subsequently injured during this process. The resident stated they informed the PSW of this and also RN #136 of the incident and pain which they identified at the site of the injury. The resident stated the home spoke to them about the incident.

An interview was carried out with PSW #141, who stated they where aware of the above incident involving resident #026. The PSW stated that on the date of the incident, the resident had informed the home that during the transfer with the PSW the resident sustained an injury. The PSW stated they had assistance from an agency staff, and they did not utilize the specified transfer equipment for resident #026 and provided transfer in a manner inconsistent with the plan of care. The PSW staff stated they were unable to recall the residents transfer status during this time.

An interview was carried out with ADOC #105, who stated staff are to always complete all transfers of residents including the use of transfer equipment in a safe manner. The CIS report, staff and resident interviews, and resident #026's plan of care were reviewed with the ADOC. The ADOC acknowledged that the staff did not practice safe transferring techniques for resident #026. (644)

Apr 10, 2020

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le :

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 31st day of October, 2019 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by JOVAIRIA AWAN (648) - (A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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Service Area Office / Bureau régional de services : Central East Service Area Office