Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jan 7, 2020	2019_718751_0006	012450-19, 016930-19, 020334-19	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

ASAL FOULADGAR (751), AMANDEEP BHELA (746), SUSAN SEMEREDY (501)

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): December 18, 19, 20, 23, 24, 27, 30, 31, 2019, January 2 and 3, 2020.

This inspection was conducted concurrently with Complaint Inspection #2019_594746_0026.
PLEASE NOTE a Written Notification related to O. Reg. 79/10, s. 36, was identified in this inspection and has been issued in the above complaint inspection report.

During this inspection the following intakes were inspected:
One intake related to Personal Support Services, transferring and positioning techniques.
Two intakes related to Falls Prevention.

During the course of the inspection, the inspector(s) spoke with the Interim Executive Director (I-ED), Interim Director of Care (I-DOC), Associate Director of Care (ADOC), Physiotherapist (PT), Environmental Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), substitute decision-makers (SDMs), and residents.

During the course of the inspection, the inspector(s) observed residents, their home area, staff to resident interactions, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services

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. (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).

Findings/Faits saillants :

The licensee has failed to ensure resident #022's written plan of care set out clear direction to the staff who provided direct care to the resident.

The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) Report related to resident #022 who had a fall with injury. The resident was found on the floor by a staff member and no injury was found at the time of the incident. The resident was assessed by team members and sent to the hospital four days after the fall incident due to an injury noted in a test result.

A review of resident #022's electronic record indicated resident had cognitive impairment, required an assistive device for mobility, and assistance from team members to complete specific Activities of Daily Livings (ADLs). A review of the resident's progress notes in Point Click Care (PCC) documented by physiotherapist #122 prior to the fall incident, indicated the resident required two specific equipment as part of falls prevention interventions. During record review, the mentioned equipment were not noted in the resident's current written plan of care. Further review of the resident's current written plan of care indicated the resident was at moderate risk for a fall and required another identified equipment on their mobility device with regards to falls prevention interventions.

During multiple observations during the inspection period, resident #022 was noted to have the two falls prevention equipment in place, however the third falls prevention equipment was not observed to be on resident's mobility device.

In an interview with Personal Support Worker (PSW) #116, they confirmed the two existing devices for falls prevention were not noted in the resident's written plan of care. When asked, PSW #116 stated resident #022's other falls prevention equipment had

been removed due to the substitute decision-maker's (SDM's) request and was unaware of any further details about the same.

During an interview, Registered Practical Nurse (RPN) #107, confirmed the existing two falls prevention equipment for resident #022 were in place but not indicated in the resident's written plan of care. RPN #107 stated they would follow up with the physiotherapist regarding the other identified equipment on resident's mobility device as indicated in the resident's written plan of care. A review of progress notes in PCC documented by RPN #107 on the same day after the interview, indicated that the resident did not require the identified equipment on their mobility device due to a specific alteration implemented on resident's mobility device.

In an interview, the Associate Director of Care (ADOC) #117 acknowledged the above and confirmed the resident's written plan of care did not set out clear directions to staff and others who provide direct care to the resident in terms of fall prevention interventions. [s. 6. (1) (c)]

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, to be implemented voluntarily.

Issued on this 20th day of January, 2020

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

Original report signed by the inspector.