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_594746_0026	016808-19, 021212-19, 021305-19, 021436-19, 021931-19	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

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

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

A Written Notification related to O. Reg. 79/10, s. 36, identified in concurrent inspection # 2019_718751_0006 were issued in this report.

**One log related to restorative care and personal support services
Two logs related to related to plan of care
Two logs related to related to transferring and positioning technique**

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), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSW), Physiotherapist (PT), Environmental Manager (ESM), residents and Substitute Decision Makers (SDM's)

During the course of the inspection, the inspector(s) conducted observations of staff and resident interactions and resident to resident interactions; reviewed health records, staff records, staffing schedules, home's complaint and critical incident system investigation records, and relevant policies and procedures.

**The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Personal Support Services
Prevention of Abuse, Neglect and Retaliation**

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	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 has failed to ensure that resident #021's Substitute Decision Maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The Ministry of Long-Term Care (MLTC) received a complaint, related to the home failing to inform resident #021's SDM about the result of a test which indicated a change in resident's status. At the time of conducting the test, the change in status was noted to be healing.

An interview with the complainant indicated that they were informed that the resident had a healed injury, however they were not informed by the home when it was initially identified. The resident had a test done on an identified date as part of an assessment for another health condition. The MLTC also received a Critical Incident System (CIS) Report indicating resident #021's SDM had concerns related to negligence of the home concerning resident's health.

Review of the home's policy #VII-A-10.20, revised in May 2019, with title “Change of Status - Notification of SDM/Family” stated that the SDM shall be notified of changes affecting the resident and/or changes in resident's status to ensure ongoing communication between the interprofessional care team and the SDM. Further review of the home's policy indicated documentation will be made in the progress notes and shall include at minimum, date and time of contact made/or attempts to contact and name of the person to whom the notification was provided.

Review of resident #021's progress notes did not indicate if the SDMs were informed of the finding of the test on the identified date.

Three test results between an identified time period, showed varying stages of healing of the injury.

In an interview with Registered Nurse (RN) #104, they stated resident/SDM consent were required when there was a new physician order. RN #104 stated resident #021's SDMs were not informed about the incidental finding of resident's healing injury on the identified date, and the physician's orders for follow up tests.

In an Interview with Interim Director of Care (I-DOC) #115, physician orders, progress notes, chest x-rays, and the home's investigation notes related to resident #021 were reviewed. I-DOC #115 stated according to the home's policy, the registered staff are to

communicate any new physician’s orders for lab work that are not routinely done to the residents’ SDMs and obtain their consent in order to carry out the physician’s order. I-DOC #115 stated that registered staff failed to inform resident #021’s SDMs about the resident’s healing injury when it was initially identified incidentally in resident’s test on an identified date. [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 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, to be implemented voluntarily.

WN #2: 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 has failed to ensure that resident #021 was protected from abuse by staff member #120.

The definition of “Abuse” in subsection 2 (1) of the Act "physical abuse" means the use of physical force by anyone other than a resident that causes injury or pain. Physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances. O. Reg. 79/10, s. 2 (2).

The Ministry of Long-Term Care (MLTC) received a complaint on an identified date indicating a Personal Support Worker (PSW) was rough during care with resident #021. In an interview with resident's SDM, they stated they had recorded their own video surveillance in the resident's room but had not informed the home about it. The video was viewed with inspectors #746 and #501. The recording was date and time stamped and showed PSW #120 providing resident #021 care in a rough manner.

A review of the home's policy #VII-G-10.00 titled Prevention of Abuse & Neglect of a Resident, revised in April 2019, stated the organization has a Zero tolerance policy for Resident Abuse and Neglect. The home's policy attachment #VII-G-10.00(a) titled Definition of Abuse on page one, revealed that any undue physical force by team members when providing care to a resident and rough handling constitute physical abuse. Further review of the home's policy # VII-G-10.00(a), definition of physical abuse on page one stated physical abuse is not the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force is excessive in the circumstances.

Inspector shared the video with the home's Interim Executive Director (I-ED) #112, Interim Director of Care (I-DOC) #115, and Associate Director of Care (ADOC) #117 with inspector #746 and #501 present. I-Ed #112 and I-DOC #115 confirmed that PSW #120 was rough during care with resident #021 which was considered physical abuse and had put resident at risk of harm. During the interview with I-ED #112 ,I-DOC #115 and ADOC #117, they stated they would initiate their investigation immediately and indicated the PSW in the video was most likely PSW #120. Review of resident #021's Point of Care (POC) documentation on an identified date revealed that PSW #120 provided care to resident on the identified date.

Review of resident's assessment indicated resident required extensive assistance from one staff for specific care needs. Further review of the assessment revealed that resident had no mood or behavior issues.

In an interview with PSW #120, they confirmed they were the staff member providing care to the resident in the recorded video on the identified date. PSW #120 admitted they were rough when providing care to resident #021 and that they used excessive force when providing care to the resident.

Separate interviews conducted with I-ED #112 and I-DOC #115 and they confirmed that

according to the video recording shared with the home, PSW #120 provided rough care to resident #021 which constitute as physical abuse. [s. 19. (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 to ensure that the home will protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: 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.

The Ministry of Long-Term Care (MLTC) received a complaint from resident #011’s family member related to an incident which resulted in the resident #011 sustaining an injury. The home also submitted a critical incident system (CIS) report related to the same incident that occurred on an identified date. According to the CIS report the resident was sent to the hospital.

A review of resident #011’s written plan of care, indicated that resident required an identified level of assistance for care. A review of resident #011’s progress notes indicated the resident sustained a fall on an identified date and time. According to this note, the resident had sustained an injury. The note indicated the events which occurred during the time of the incident according to the PSW’s. Further progress notes revealed resident #001 was sent to the hospital and returned the same day after receiving treatment for there identified injury.

An interview with PSW #100 indicated they were not resident #011's primary care giver but were assisting PSW #113 with the care. During care, resident #001 was injured.

An interview with RN #104 who responded to the above incident, indicated resident #011 was injured during the course of care. According to the RN, the PSWs received training the same day.

The home failed to ensure that staff used safe transferring and positioning techniques when assisting resident #011. [s. 36.]

2. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.
The home submitted a CIS report indicating resident #012 sustained an injury while being transported to their room. At the time of the incident there was no injury noted. On a later date, resident #012 was sent to the hospital as they were complaining of pain and returned to the home, with an injury.

A review of resident #012's written plan of care, indicated the resident used a mobility device, which allowed them to mobilize independently but at times required staff for assistance with mobility. As well, the plan of care stated the resident would like to have a female PSW to assist them with their care and activities of daily living.

A review of the home's investigation notes related to this incident indicated the video surveillance cameras were watched by Interim Executive Director (I-ED) #112. At an identified time, the resident was being assisted to their room in the resident's identified mobility device. The camera showed the resident attempted to resist with an identified action while being assisted back to their room and tried to stop the PSW from continuing, which resulted in the resident sustaining an injury, the resident was observed to express pain on their face.

According to the home's investigation notes, a male PSW #105 decided to assist the resident with PSW #111. The resident became upset so PSW #110 who was assigned to the resident, attempted to take the resident back to their room. The resident resisted and sustained an injury during the mobility due to PSW #110 failing to ensure the device was in a safe state for transporting the resident.

Interview's with male PSW #105 and PSW #111 corroborated the homes investigation notes which led to the injury. Male PSW #105 further indicated that they were not aware

that the resident #012 preferred not to have male caregivers.

An interview with RPN #107, who PSW #110 reported the incident to, stated they initially assessed resident #012 and at the time, the resident said they were not in pain. The RPN indicated that resident #012 could have been upset in part due to thinking they were being cared for by a male PSW.

An interview with I-ED #112 confirmed the staff failed to use safe transferring and positioning devices or techniques when assisting resident #012 in the above-mentioned incident.

These findings are further evidence to support the order issued on November 8, 2019, during critical incident system inspection # 2019_685648_0018 (A3) to be complied April 10, 2020. [501] [s. 36.]

Issued on this 16th day of January, 2020

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

Original report signed by the inspector.