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
Feb 3, 2022	2022_875501_0001	013817-21, 014995-21, 015360-21, 017482-21, 018801-21	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

SUSAN SEMEREDY (501), NICOLE LEMIEUX (721709)

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): January 11, 12, 13, 25 and 26, 2022.

The following intakes were completed in this critical incident (CI) inspection:
Log #018801-21: Follow-up to CO#001 from inspection #2021_595110_0010 regarding falls prevention and management, s.8(1)(b) of the O.Reg. 79/10, with a compliance due date of October 30, 2021;
Log #013817-21 related to falls prevention and management;
Log #014995-21 related to falls prevention and management;
Log #015360-21 related to falls prevention and management; and,
Log #017482-21 related to an injury of unknown cause.

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

During the course of the inspection, the inspectors observed resident and staff interactions and IPAC practices. The inspectors reviewed clinical health records, relevant home policies and procedures and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **5 VPC(s)**
- **0 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
O.Reg 79/10 s. 8. (1)	CO #001	2021_595110_0010	501

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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that re-assessment and interventions were documented, specifically not documenting a post fall interdisciplinary discussion after each fall.

A resident had a fall in which an injury was sustained. Record review indicated that a post fall interdisciplinary discussion related to this fall was not documented. As a result, contributing factors and ineffective or new interventions implemented related to the fall were not documented in progress notes to ensure all interdisciplinary team members were aware.

An ADOC acknowledged that a post fall interdisciplinary discussion in the post fall assessment should have been documented.

Sources: A resident's health records and assessments including electronic and physical chart and interview with an ADOC. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, re-assessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

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

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring techniques when assisting a resident.

A resident was noted to have responsive behaviours and complained of pain to an RPN who noticed that the resident had signs there was an injury. The resident was later seen on the floor and the RPN and a PSW transferred the resident without using an assistive device. An interview with the DOC confirmed that transferring a resident with a suspected injury without an assistive device was unsafe as possible further injury could have occurred.

Failing to use safe transferring techniques puts residents at actual risk of harm.

Sources: A resident’s progress notes, the home’s investigation notes and interviews with an RPN and the DOC. [s. 36.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that actions were taken to respond to a resident's responsive behaviours.

The resident had a history of responsive behaviours and had interventions in place to address these behaviours. At one time the resident's behaviours escalated and an injury occurred. It was determined that the staff did not implement interventions that might have prevented this injury.

Failing to take action for a resident exhibiting responsive behaviours put the resident at actual risk of harm.

Sources: The home's investigation notes, a resident's care plan and progress notes, and interviews with an RN and the DOC. [s. 53. (4) (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 for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who required assistance was not served a meal until someone was available to provide the assistance required by the resident.

A resident was given a meal tray in their room which was placed on the over-the-bed table. The resident was asleep in their bed at the time and was not woken. The resident woke but did not realize a meal had been served. Forty minutes later a PSW who was picking up dirty trays entered the room and realized the resident had not eaten. Another PSW entered the room and both assisted the resident out of bed into their chair and set up their meal. They did not offer to heat up the meal. The IPAC Lead acknowledged the staff should have reapproached the resident sooner.

By serving a meal before assistance was available put the resident at risk of not having an opportunity to have their meal or refusing to eat their meal because the temperature was no longer palatable.

Sources: Observations and interviews with the IPAC Lead and other staff. [s. 73. (2) (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 no resident who requires assistance with eating and drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

The entire home was in COVID-19 outbreak since January 5, 2022 and all residents were being isolated in their rooms under contact and droplet precautions.

The following observations were made during the inspection:

Wearing of Eye Protection:
• An staff member was not wearing eye protection when in a resident room and providing assistance with eating.

Sanitizing of Eye Protection:
• During no time during observations on all floors did the staff sanitize their eye protection when exiting a resident room. A staff member indicated they only do this once they have finished what they are doing but not after exiting every resident room.

Putting on and taking off of Personal Protective Equipment (PPE):
• A staff member was in a resident room with a gown that was untied and falling down on their chest, came out of room and walked down the hall to sanitize their hands and then took off their gown.
• A staff member was in a resident room without wearing a gown or gloves.

Assisting Residents with Hand Hygiene:
• During a meal service residents were being served trays in their rooms. The residents were not offered or assisted to perform hand hygiene before or after their meal.

During an interview the IPAC stated that the home expected staff to treat all residents as though they were suspected or confirmed cases of COVID-19. The IPAC Lead acknowledged that the home's IPAC program included assisting residents with hand hygiene before and after meals, wearing the appropriate PPE which included putting on and taking off PPE properly and sanitizing eye protection when exiting a resident room.

Sources: Observations and an interview with the IPAC Lead and other staff. [s. 229. (4)]

2. The licensee has failed to ensure that there was in place a hand hygiene program in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents.

It was observed that staff members when exiting resident rooms at times had to walk down approximately six feet to access alcohol-based hand rub (ABHR) stations when putting on and taking off their PPE. According to Public Health Ontario (PHO) placement of ABHR should facilitate hand hygiene when putting on and taking off PPE. An interview with the IPAC Lead acknowledged that portable or pump bottles could be placed at the entrance/exit of every room.

Failing to ensure staff have access to ABHR when donning and doffing the PPE risks the transmission of infectious disease.

Source: PHO - PIDAC "Best Practices for Hand Hygiene in All Health Care Settings. 4th Edition, April 2014", observations and an interview with the IPAC Lead. [s. 229. (9)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participated in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #6: 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 has failed to ensure the Falls Prevention and Management Policy included in the required interdisciplinary falls prevention and management program was complied with, for residents #001 and #003.

O.Reg. 79/10, s. 48 (1) 1 required the home to have an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

Specifically, staff did not comply with the home's "Falls Prevention and Management" policy, dated February 2020. The policy directed registered staff to conduct a thorough investigation of the fall incident including all contributing factors, and to initiate a head injury routine if the fall was unwitnessed and the resident was on anticoagulant therapy.

Resident #003 had a fall and sustained an injury. The resident was at high risk for falls. Interventions to prevent falls and injuries from falls were in place. A post fall note by the RPN who attended the scene documented an intervention was checked but did not indicate whether it was in working order or not. Another intervention that the resident was to be wearing was not identified as being in place. A review of the falls risk management note for this incident indicated that it was suspected the resident was ambulating to perform an activity of daily living (ADL) without assistance.

Interviews with the PT and an ADOC indicated that when doing a post-fall assessment staff should look at whether interventions within the resident's care plan were implemented and what measures could be taken to prevent further falls. Both the PT and ADOC acknowledged that for resident #003's fall as described above, the home's investigation did not include whether interventions were in place at the time of the fall and

whether the resident could benefit from a routine related to performing an ADL.

The resident continued to have falls and an interview with the ADOC acknowledged the home did not conduct a thorough investigation of these falls including all contributing factors.

Failing to conduct a thorough investigation of fall incidents puts residents at risk for further falls.

Sources: The home's Falls Prevention and Management policy, resident #003's progress notes and care plan and interviews with the PT and ADOC #102. [s. 8. (1)]

2. Resident #001 had an unwitnessed fall in which an injury was sustained and was receiving a type of medication that put them at risk should a head injury have occurred. Upon review, it was determined that a head injury routine was not initiated after this fall. As per the home's policy it was indicated that a head injury routine was to be initiated if a fall was unwitnessed and the resident was receiving a type of medication. As a result, increased monitoring of the resident was not completed that would have assisted in alerting staff to a change in the resident's status.

An RPN and ADOC both acknowledged that a head injury routine should have been initiated post fall and was not completed as per the home's policy.

Sources: Resident #001's health records and assessments including electronic and physical chart, Falls Prevention and Management policy, interviews with an RPN and ADOC. [s. 8. (1)]

WN #7: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that reports made to the Director included the names of any staff members who discovered the incident.

A review of a Critical Incident System (CIS) report submitted to the Director did not include the staff member who discovered the incident. An interview with the DOC confirmed this report did not include the above-mentioned information.

Sources: CIS report and an interview with the DOC. [s. 107. (4) 2. ii.]

Issued on this 8th day of February, 2022

[redacted]

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

Original report signed by the inspector.