Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
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Original Public Report

Report Issue Date: April 28, 2023

Inspection Number: 2023-1052-0001

Inspection Type:
Complaint
Critical Incident System

Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.

Long Term Care Home and City: Rockcliffe Care Community, Scarborough

Lead Inspector	**Inspector Digital Signature**
April Chan (704759)	April W Chan Digitally signed by April W Chan Date: 2023.05.09 15:29:44 -04'00'

Additional Inspector(s)
Nital Sheth (500)
Henry Chong (740836)
Yannis Wong (000707)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: April 11-14, 17-18, 2023.

The following intakes were inspected:

- Intake #00002269 - Critical Incident (CI) related to falls prevention
- Intake #00002963 - CI related to alleged resident to resident abuse
- Intake #00002980 - CI related to alleged resident to resident abuse
- Intake #00003012 - CI related to alleged resident to resident abuse
- Intake #00003553 - CI related to alleged resident to resident abuse
- Intake #00005534 - Complaint related to falls prevention
- Intake #00019963 - CI related to injury of unknown cause.

The following intakes were completed in the Critical Incident System Inspection. Intake #00001116, intake #00001143, intake #00001942 were related to injury of unknown cause; intake #00005138, intake #00003721, and intake #00006660 were related to falls prevention.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Safe Transferring and Positioning Techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 36

The licensee has failed to ensure that staff used safe positioning techniques when assisting a resident.

Rationale and Summary
On a specified date, the resident had a fall while a personal support worker (PSW) assisted them in bed. The PSW provided improper directions to the resident related to their turning and positioning that resulted in the incident. The PSW confirmed that if they provided proper directions, it could have prevented this incident. An Associate Director of Care (ADOC) acknowledged that the staff were required to use safe positioning techniques.

The unsafe positioning techniques used by the PSW placed the resident at potential risk of injury.

Sources: Assessments, progress notes, care plan, interviews with a PSW, and an ADOC. [500]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 53 (4) (c)

(i) The licensee has failed to ensure that actions taken to respond to the needs of residents demonstrating responsive behaviours, including assessments and reassessments, was documented for residents #004, #006, and #007.

Rationale and Summary
A number of Critical Incidents were received by the Ministry of Long-Term Care (MLTC) with regards to alleged incidents of resident to resident abuse.

Staff indicated that a direct observation tool were to be initiated after incidents of resident-to-resident altercation. An ADOC identified that the observation tool helped to identify what triggers a resident's responsive behaviours and to analyze for effectiveness of interventions.

Resident #004 had a history of responsive behaviours and was involved in an altercation with resident #006 who demonstrated responsive behaviours on a number of incidents. The direct observation tool was initiated for both residents for a number of days immediately after the incidents.

Resident #007 had a history of responsive behaviours and was involved in altercation with resident #004. The direct observation tool was initiated immediately these two residents for a number of days.

Review of resident #004, #006, #007's direct observation tools showed periods of missing information.

A registered nurse (RN) and a registered practical nurse (RPN) indicated that the direct observation tool for the above-mentioned residents was not fully documented. An ADOC and the RPN identified that the direct observation tool should not have missing information during the period of direct observation.

Sources: CI reports, review of resident #004, #006, #007's clinical record, direct observation tools, interviews with staff members and an ADOC. [704759]

(ii) The licensee has failed to ensure that when resident #005 was demonstrating responsive behaviours, the observation monitoring tool initiated was documented.

Specifically, a direct observation tool was initiated after a resident to resident altercation and there

were missing entries throughout the worksheet.

Rationale and Summary
A Critical Incident was received by the MLTC for an alleged resident to resident abuse.

After the incident of exhibiting responsibe behaviours to residents and staff and engaging in an altercation with resident #004, resident #005 had a direct observation tool initiated for a number of days. The direct observation tool was missing entries for multiple dates and times.

A registered practical nurse (RPN) and an ADOC indicated that there should not be blanks in the direct observation tool. They both identified that for the blank times, monitoring was not documented.

There was minimal risk identified when direct observation tool was not documented for residents #004, #005, #006, #007 who were demonstrating responsive behaviours, because the ADOC was able to analyze trends in combination with clinical notes.

Sources: CI report, resident #005's direct observation tool, clinical records, interviews with an RPN and an ADOC. [000707]

WRITTEN NOTIFICATION: Retention of Resident Records

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 276 (1)

The licensee has failed to ensure that the record of a former resident was retained for at least 10 years after the resident was discharged from the home.

Rationale and Summary
The resident lived in the home for a period of time, and was discharged within the past 10 years from the time of the inspection. Paper-based record of the resident was requested for review. During the course of the inspection, the home was not able to locate and produce the resident’s paper record from their archives.

Sources: review of the resident's census and electronic clinical notes, interviews with an ADOC, Director of Care (DOC), Executive Director (ED). [704759]