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
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: January 15, 2024

Inspection Number: 2024-1052-0001

Inspection Type:
Critical Incident

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

Long Term Care Home and City: Rockcliffe Community, Scarborough

Lead Inspector	**Inspector Digital Signature**
Ramesh Purushothaman (741150)	Ramesh Purushothaman Digitally signed by Ramesh Purushothaman Date: 2024.01.16 08:59:49 -05'00'

Additional Inspector(s)
Cindy Cao (000757)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 3-5, 8 and 9, 2024

The following intake(s) were inspected:

- Intake: #00098913 was related to alleged resident to resident physical abuse.
- Intake: #00099113 and #00100839 were related to Infection Prevention and Control Program (IPAC).
- Intake: #00099218 was related to fall prevention and management program.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 20 (b)
Communication and response system
s. 20 (b) is on at all times;

The licensee has failed to ensure that resident #003's call bell was on at all times.

Rationale and Summary
The inspector observed the resident #003's call bell was not on when pressed multiple times. Interview with Personal Support Worker (PSW) #103 admitted that they did not check whether resident's call bell was working during their shift that day. PSW #103 confirmed the connection of resident's call bell was off and

therefore not functioning at the time of the observation. PSW acknowledged the call bell should have been on at all times for the resident.

Observation done later, on another date, the inspector noted resident #003's call bell was functional when activated.

Failure to ensure the call bell was functional at all times may lead to delayed staff response to resident's call.

Sources: Observations, and interview with PSW #103.

Date Remedy Implemented: January 9, 2024.
[000757]

WRITTEN NOTIFICATION: MAINTENANCE SERVICES

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (b)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

The licensee had failed to ensure that resident #004's bed alarm was kept in good repair.

Rationale and Summary
Resident #004 had a fall and was found sitting on the floor beside the floor mat. The resident sustained an injury and was transferred to the hospital. The resident

returned from the hospital after receiving treatment to their injury.

The resident used a device as part of their fall prevention intervention strategy. Registered Practical Nurse (RPN) #108 acknowledged that they were not alerted by the device at the time of the resident's fall. According to the resident's progress notes, the device was on but was not functional.

Associate Director of Care (ADOC) #111 stated that at the beginning of each shift, PSW staff were responsible to ensure that the device was in working order. Additionally, the ADOC confirmed that, the day after the fall, a request was sent to the maintenance department to check the device and to ensure it was working. ADOC stated that the device would help the staff to respond to the resident quicker if there was any need.

Failure to ensure resident #004's fall prevention device was in good repair resulted in a delay in staff responding to the resident's fall.

Sources: Resident's clinical records, Critical Incident Report, interviews with PSW, RPN and ADOC.

[741150]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure the implementation of a standard issued by the Director with respect to infection prevention and control (IPAC). The home has failed to ensure that Routine Practices were implemented in accordance with the "IPAC Standard for Long-Term Care Homes April 2022". Specifically, hand hygiene, including the four moments of hand hygiene, as required by Additional Requirement 9.1 (b) under the IPAC standard.

(i) PSW #104 was observed, assisting residents in their assistive devices, close to the elevator area in order to get them ready for meals. The PSW did not perform hand hygiene before and after assisting residents.

The same PSW was later observed removing cups and glasses from different resident rooms and did not perform hand hygiene before and after removing the utensils from residents' rooms.

The home's policy titled "Hand Hygiene" indicated, according to four moments of hand hygiene, all team members should perform hand hygiene before and after resident environment contact.

IPAC lead #105 confirmed the staff were expected to perform hand hygiene before and after resident environment contact.

Failure to ensure hand hygiene was performed according to routine practices increased the risk of infectious disease transmission.

Sources: Observation, IPAC Standard for LTCH's last revised April 2022, Home's

hand hygiene policy # 1X-G-10.10 last revised 11/2023. interviews with PSW and IPAC lead.
[741150]

The licensee has failed to ensure that staff used appropriate personal protective equipment (PPE) in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022". Specifically, staff did not don and doff required Personal Protective Equipment (PPE) properly as per additional precaution 9.1 (d) under the IPAC standard.

(ii) PSW #103 was observed inside the resident room without a gown where a resident was placed on isolation precautions. The PSW exited the room without performing hand hygiene. PSW #103 went again into the same room to provide care and before donning the gown they did not perform hand hygiene. After providing resident care, the PSW left the room without changing their surgical mask.

Housekeeper #102 was observed coming out of the same resident room without a gown. The housekeeper did not change the mask after exiting the resident room.

The PSW and the housekeeper both admitted that they had not followed the proper donning and doffing procedures including hand hygiene as stipulated. The staff clarified that they were supposed to wear gowns before entering any resident rooms on isolation precautions and to remove contaminated masks when they left the room.

IPAC lead #105 acknowledged that the staff were expected to wear gowns when entering a resident room on isolation precautions. The staff were expected to follow the correct donning and doffing procedures and to discard the face mask when exiting the resident room.

There was risk of infectious disease transmission when the correct donning and doffing Personal Protective Equipment (PPE) procedures were not followed.

Sources: Observations, IPAC Standard for LTCH's last revised April 2022, interviews with PSW and IPAC lead.
[741150]

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