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: October 25, 2024

Inspection Number: 2024-1052-0004

Inspection Type:
Critical Incident

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

Long Term Care Home and City: Rockcliffe Community, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 18, 19, 20, 23, 27, 30, 2024
The inspection occurred offsite on the following date(s): October 2, 2024
The following intake(s) were inspected:

- Intake: #00120941 - Critical Incident (CI) - alleged physical abuse from staff to resident
- Intake: #00125354 - (CI) and #00125945 -(CI) - physical abuse from resident to resident

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

Infection Prevention and Control
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 2.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

2. Every resident has the right to have their lifestyle and choices respected.

The home has failed to respect and promote a resident's right to their lifestyle and choices.

Summary and Rationale

On a specified date, a resident was not offered a second choice of entrée for a meal and became irritated.

The resident did not eat the second option on the menu, for personal reasons. On a specified date the menu indicated two choices for the meal. Staff presented to the resident only one choice and not the other because they assumed the resident would refuse. The resident commented about the food and the situation escalated.

The Director of Dietary Services (DDS) indicated that for residents who do not eat the offered second choice as per the standard menu, would be offered an alternative meal. Staff did not offer the resident a second choice because they assumed they would refuse.

Interview with the resident indicated that they had shared with the home alternatives to second choice for meals.

Failure to offer the resident a second choice of entree did not respect and promote their lifestyle and choices.

Sources: Progress notes, investigation records; interviews with the resident, and home's staff.

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WRITTEN NOTIFICATION: Responsive Behaviour

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (2) (c)
Responsive behaviours
s. 58 (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(c) co-ordinated and implemented on an interdisciplinary basis.

The licensee has failed to ensure that resident #001's responsive behaviour was co-ordinated and implemented on an interdisciplinary basis.

Rationale and Summary:

On a specified date, a resident allegedly reported to their family that while being provided care they sustained injuries.

The resident was initiated on a Dementia Observational System (DOS) monitoring because of a new behaviour.

Staff noted that the resident was confused, agitated, and was talking more loudly than usual. The staff tried to calm the resident down without success. They tried to provide care to the resident. Later the PSW reported to the Registered Practical Nurse (RPN) that the resident presented with new responsive behaviour.

As per the home's policy Responsive Behaviours Management, VII-F-10.10, from November 2020, the Personal Support Worker will recognize, verbally report, and

document on a daily basis any resident with noted changes in behaviour using Point of Care (POC) or paper documentation.

Interview with the Behaviour Support Ontario (BSO) lead, an RPN and review of the home investigation record of the resident's responsive behaviours, indicated that the PSW did not inform the RPN of the new responsive behaviours.

Failure to report the resident's responsive behaviours poses the risk of not having a coordinated and interdisciplinary approach.

Sources: Progress notes, investigation records; interviews with the home's staff.

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