Ontario

**Ministry of Health and Long-Term Care**

**Inspection Report under the Long-Term Care Homes Act, 2007**

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée***


**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

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**Public Copy/Copie du public**

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| May 23, 2019 | 2019_594746_0008 | 025973-18, 005570-19 | 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)

## 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): March 28, 29, April 1, 2, and 3, 2019.**

**During the course of the inspection the following complaint intakes were inspected.**
**025973-18 related to transferring and positioning technique.**

**A Voluntary Plan of Correction related to s. 6 (5) of the Long-Term Care Homes Act, S.O. 2007, identified in this complaint inspection #2019_594746_0008 (025973-18, 005570-19) will be issued under concurrent complaint inspection #2019_486653_0008 (Log #s 021688-17, 022577-17).**

**During the course of the inspection, the inspector(s) spoke with Personal support workers (PSWs), Registered Nurse (RN), Director of Care (DOC) and Substitute Decision Maker (SDM).**

**During the course of the inspection the inspector conducted observations of resident care provision, reviewed health records, critical incident report, and the home's investigation notes.**

**The following Inspection Protocols were used during this inspection:**
**Personal Support Services**
**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 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 :**

The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting residents.

The Ministry of Health and Long-Term Care (MOHLTC) received a complaint, related to

an injury sustained by resident #014 while being provided an identified care.

An interview with the complainant was carried out and they indicated that resident #014 was put in harm's way as a staff member of the home did not provide the identified care to the resident and the resident sustained an identified injury and was transferred to hospital for further assessment.

A review of resident #014's written plan of care for an identified time period indicated they required an identified number of staff for assistance with an identified care.

A review of progress notes on an identified date indicated the Executive Director (ED) and the Director of Care (DOC) were called to an identified location to assess resident #014's identified injury. The family was notified of the incident and transferred to hospital.

The resident returned to the home from the hospital on an identified date and hospital discharge summary indicated that the resident sustained an identified injury.

Interviews were conducted with PSW #133 and Registered Nurse (RN) #120, and the staff indicated that it was the home's expectation, when carrying out an identified care to resident there was to be two trained staff members present during the care.

An interview with PSW #131 confirmed they worked on an identified date and attempted to provide an identified care to resident #014 while student PSW #143 observed. PSW #131 indicated the resident was presenting with an identified response prior to the identified care being provided. The PSW indicated they called the student PSW to observe the identified care being provided which was to be carried out by two people. The PSW indicated as they proceeded to provide the identified care on their own, the resident presented with an identified response to the care being provided and sustained an injury in an identified location of the body. The PSW acknowledged they did not provide the identified care to resident #014 with trained home staff present.

A review of the home's investigation notes was carried out related to the above incident which occurred on an identified date, involving resident #014. The investigation notes indicated PSW #131 did not provide the identified care to the resident with trained home staff present which resulted in an identified injury to the resident where by the resident was transferred to hospital for their identified injuries.

An interview was conducted with the DOC related to the incident with PSW #131 and resident #014. The DOC acknowledged that the PSW was required to have a trained staff member prior to providing the identified care to resident #014.

***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.***

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**Issued on this 24th day of May, 2019**

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

**Original report signed by the inspector.**