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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 13, 2019	2019_684604_0007	019628-18	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

SHIHANA RUMZI (604)

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 20, 21, 22, 25, 26, 27, 28, 29, April 1, 2, 3, 4, and 5, 2019.

Complaint intake log #019628-18, was inspected related to multiple care areas.

A Compliance Order (CO) related to s. 6 (7) of the Long-Term Care Homes Act, S.O. 2007, identified in this report for resident #022 will be issued under concurrent Critical Incident System (CIS) inspection report #2019_486653_0010, log #001494-18.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), and Substitute Decision Maker (SDM).

During the course of the inspection, the inspector conducted observations on staff to resident interactions, provisions of care, conducted reviews of resident health records, home's complaint and missing items binder, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care
Sufficient Staffing

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

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. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

The licensee has failed to ensure that in making a report to the Director under subsection 23 (2) of the Act, the licensee included the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report including the date and time of the incident and the events leading up to the incident.

The Ministry of Health and Long Term Care (MOHLTC) ACTIONline received a complaint on an identified, from complainant #100 who had concerns related to resident #022 not receiving appropriate care.

Inspector #604 reviewed the home's Critical Incident System (CIS) report, received on an identified date to the MOHLTC Director indicating an incident had occurred related to neglect of resident #022 by a staff member.

An interview was conducted with complainant #100 indicated resident #022 was not provided with identified care and they had informed the evening RPN whose name they were unable to recall.

An interview was conducted with ADOC #116, who had completed the identified CIS report related to an incident which involved resident #022, who was not provided identified care during and identified shift. The CIS report did not consist of the accurate date and time of the incident, the home's review of the camera footage by the DOC, and events leading up to the incident. The ADOC indicated that the previous DOC had not amended the submitted CIS report with the required information and the DOC had not communicated the information to the ADOC prior to them leaving. The ADOC acknowledged that the required information was not provided to the MOHLTC Director as per regulation.

An interview was conducted with the DOC #112, who stated the family of resident #022 had sent the DOC and Executive Director (ED) an email on an identified date, of an incident which occurred which showed resident #022 not receiving identified care for an identified duration of time. The DOC stated they reviewed the PCC progress notes and watched the camera footage for the identified date of the incident. The DOC acknowledged that CIS report did not consist of the actual date of the incident and the CIS report also did not include the home's review of the camera footage by the DOC, and events leading up to the incident as required by the MOHLTC Director.

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 insure that in making a report to the Director under subsection 23 (2) of the Act, the licensee included the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report including the date and time of the incident and the events leading up to the incident,, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

The Long-Term Care Homes Act (LTCHA),2007 O. Reg 79/10, defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The Ministry of Health and Long Term Care (MOHLTC) ACTIONline received a complaint on an identified date, from complainant #100 who had concerns related to resident #022 not receiving appropriate care.

An interview was conducted with complainant #100 who stated that resident #022 was not provided with identified care on an identified date. The complainant indicated they reported the concern to the Registered Practical Nurse (RPN) whose name they could

not recall.

Inspector #604 conducted a review resident #022's PCC progress notes for an identified period of time, and reviewed a note for an identified date, documented by RN #118. The note stated the resident was found have not received identified care and care was provided to the resident by two PSW staff. The RPN updated family member as requested.

A review of resident #022's written plan of care was carried out with a focus related to an identified care need to be provided to the resident by two staff extensive assistance.

An interview was conducted with RPN #119, who stated resident #022's family member approached them with concerns that care had not been provided. The RPN stated they immediately assessed the resident. The RPN stated upon observation of resident #022 confirmed the identified care was not provided to the resident and immediately had two Personal Support Worker (PSW) staff attend to the resident. The RPN stated they reported the incident to RN #118.

An interview was conducted with RN #118, confirmed they worked on and identified date and shift and they reviewed the PCC progress notes with Inspector #604, for and identified date, for resident #022. The RN stated that RPN #119 who worked the on an identified shift and date, informed them the family member of resident #022 had concerns that care was not provided.

An interview was carried out with PSW #114, who confirmed they worked on an identified date and shift with resident #022 who was on their regular block/assignment and was identified as requiring identified care. The PSW stated that resident #022 would inform them when they needed an identified care and on an identified date, the PSW didn't attend to resident #022 as the resident did not voice any concern or need for care. The PSW indicated they also did not ask the resident if they needed care. The PSW stated on an identified shift and date, they did not provide the identified care to the resident for the remainder of their shift which ended at an identified time. The PSW stated the Director of Care (DOC) #112, called them and informed them of the incident which had occurred, and an investigation was conducted for neglect of not providing resident #022 with identified care.

An interview was carried out with DOC #112, who indicated the family of resident #022 had sent the DOC and Executive Director (ED) an email related to a concern where the

resident was not provided an identified care need.The DOC stated they reviewed the PCC progress notes and watched the camera footage for an identified date. The DOC stated they investigated the allegation which included a review of the video footage and stated, resident #022 was not provided care for an identified duration of time. The DOC further recognized this incident to be neglect of resident #022 as care was not provided to the resident as required.

The severity of the incident was a two as there was minimal harm/risk of potential for actual harm to the resident. The scope of this issue was a level one as it related to one resident. The home had a level four compliance history as the home had non-compliance related to LTCHA, 2007 S.O. 2007, c.8, s. 19. (1), as a CO was issued on October 12, 2018, to the home within report 2018_486653_0015. It had been confirmed through a follow-up inspection #2019_684604_0007, that the non-compliance was found under LTCHA, 2007 S.O. 2007, c.8, s. 19. (1), had been address and complied by the home since the non-compliance occurred in 2018. Therefore, a written notification will be issued within this inspection #2019_684604_0007.

Issued on this 27th day of May, 2019

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

Original report signed by the inspector.