Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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
Feb 12, 2020	2020_763116_0005	000813-20	Critical Incident System

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

SARAN DANIEL-DODD (116)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 24, 27, 28, 29, 2020.

An intake related to prevention of abuse, neglect and retaliation was completed during this Critical Incident (CIS) inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (E.D.), Director of Care (DOC), Associate Director(s) of Care (ADOC), registered staff members (RNs & RPNs), personal support workers (PSW) and residents.

During the course of this inspection the inspector observed resident to staff interactions, completed record review of resident health records, internal investigation notes, relevant home policies and relevant video surveillance footage.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care that sets out the planned care for resident #001.

A CIS report was submitted to the Director related to assertions of resident-to-resident abuse involving resident's #001 and #002.

Review of the CIS report and progress notes for both residents' indicated that resident #002 went into resident #001's room for an established amount of time. Upon resident #002 leaving resident #001's room and the unit, resident #001 expressed concerns to PSW #104 and RPN #105 regarding resident #002's visit.

A review of resident #001's progress notes and an interview held with RPN #105 shared that the concerns were reported to RN #109 and the DOC the same day resident #001 expressed concerns related to resident #002. Instruction was given by the DOC to initiate an identified intervention for resident #001.

Review of the current written plan of care did not contain the intervention for resident #001 in relation to resident #002.

During an interview with PSW #108 they disclosed being unaware of the requirement for the identified intervention for resident #001.

An interview held with the DOC acknowledged that the current written plan of care for resident #001 did not set out the planned care for resident #001. [s. 6. (1) (a)]

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 there is a written plan of care that sets out the planned care for the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any person who had reasonable grounds to suspect that abuse of a resident by anyone occurred or may occur, immediately reported the suspicion and the information upon which it is based to the Director.

A CIS report was submitted to the Director related to an incident of resident-to-resident abuse involving resident's #001 and #002.

Review of the CIS report and progress notes indicated that resident #002 went into resident #001's room for an established amount of time. Upon resident #002 leaving resident #001's room and the unit, resident #001 expressed concerns to PSW #104 and RPN #105 regarding resident #002's visit.

An interview held with PSW #104 found they were present in resident #001's room providing care to their roommate. PSW #104 stated they observed resident #001 and #002 in resident #001's room and observed an interaction between the two. PSW #104 spoke with resident #001 regarding the observations made and then reported the suspicion and verbal statement of resident #001 to RPN #105.

Interviews held with PSW #104 and RPN #105 who were assigned to resident #001, indicated that resident #001's statement vocalizing the concerns with resident #002's visit were reasonable grounds to report the suspicion to the Director immediately.

An interview held with RPN #105 indicated that the concerns were reported to RN #109 and the DOC on the same day, of which they were directed to complete a verbal complaint form and place both residents on required monitoring.

Further interview held with the DOC acknowledged that the suspicions of resident to resident abuse were not reported immediately to the Director. [s. 24. (1)]

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 any person who had reasonable grounds to suspect that abuse of a resident by anyone occurred or may occur, immediately reported the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

Issued on this 4th day of March, 2020

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

Original report signed by the inspector.