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
Jul 21, 2020	2020_838760_0012	002667-20	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

JACK SHI (760)

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): July 13, 14, 15, 16, 17, 20, 21, 2020

Log #002667-20 related to nutrition and hydration.

During the course of the inspection, the inspector reviewed records, conducted interviews and observations.

During the course of the inspection, the inspector(s) spoke with Substitute Decision Maker (SDM), Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Dietician (RD) and Associate Director of Care (ADOC).

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration

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 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. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
13. Nutritional status, including height, weight and any risks relating to nutrition care. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #004's plan of care was based on an

interdisciplinary assessment that included any risks related to nutrition care.

The Ministry of Long-Term Care (MLTC) received a complaint regarding an incident that occurred with resident #004 and resulted in them being hospitalized.

A record review of the progress notes for resident #004 indicated they had a previous similar incident but did not end up being hospitalized. After this incident, the RD assessed the resident and revised the diet in their nutritional plan of care.

A review of the progress notes of the incident noted that resident #004 was being initially being assisted by RPN #102, however the resident took over the assistance and managed to help themselves. Shortly after, a PSW called for help and noticed resident #004 had a change in condition. RPN #102 applied medical interventions after assessing the resident. Emergency 911 was called and the paramedics arrived and provided further medical interventions which allowed resident #004's condition to improve and was sent to the hospital and admitted for further assessment. The resident came back from the hospital and recommendations were provided from the hospital related to the diet on their nutritional plan of care. The home’s RD conducted an assessment shortly after and followed through with the hospital’s recommendation for resident #004.

A record review of resident #004’s written plan of care did not specify that they had a nutritional risk related to the two incidents that previously occurred.

An interview with RPN #102 confirmed the events that was documented in resident #004’s progress notes and that they had an identified nutritional risk related to the incidents that previously occurred and required supervision from staff as a result.

An interview with PSW #101 also confirmed the same information as RPN #102 with regards to resident #004. PSW #101 reviewed resident #004’s written plan of care and confirmed that it did not indicate their identified nutritional risk related to the previous incidents that occurred. PSW #101 stated that the identified nutritional risk should be on resident #004’s written plan of care, similar to if they were at high risk for falls.

RD #105 was interviewed and confirmed that resident #004 had the identified nutritional risk and thus they revised the diet on their nutritional plan of care. RD #105 indicated the home’s care plans were changed and information on them were reduced. RD #105 stated that the identified nutritional risk would be indicated in a resident's nutritional assessment and only on a resident’s care plan if the resident and/or their SDM went

against the recommendations from the RD. RD #105 stated they believe staff would be aware of a resident's nutritional risk from the information related to the diet on their plan of care.

An interview with ADOC #106 confirmed that resident #004 had the identified nutritional risk and that this information should be on their plan of care. ADOC #106 reviewed resident #004's written plan of care and noticed that staff updated resident #004's plan of care on the same day the inspector interviewed them, indicating their nutritional risk. ADOC #106 stated this information should have been on resident #004's plan of care prior to the inspector bringing this forward to the staff during their interviews. [s. 26. (3) 13.]

2. Resident #007 was selected for sample expansion after non-compliance was identified with resident #004.

A record review of resident #007's written plan of care indicated they had an identified diet in their nutritional plan of care.

An interview with PSW #109 confirmed that resident #007 was on this identified diet and thus, they had a higher identified nutritional risk.

An interview with RPN #107 indicated that when a resident is placed on an identified diet, they are at a higher identified nutritional risk. RPN #107 indicated that this information would be found on a resident's plan of care. RPN #107 confirmed resident #007 was on that identified diet and had the higher nutritional risk. RPN #107 reviewed resident #007's written plan of care and stated that this nutritional risk was not in their plan of care and that this information should have been added on there.

RD #105 was interviewed and indicated that resident #007 was assessed and changed to the identified diet due to an identified nutritional risk. RD #105 indicated that the nutritional risk was not identified in resident #007's written plan of care because of the home's policy to reduce information on a resident's plan of care.

Inspector #760 mentioned to RD #105, that during their interview for resident #004, RD #105 indicated that if a resident was on the identified diet, it means they had a higher identified nutritional risk. Inspector reviewed resident #009's nutritional status with RD #105 as part of the sample expansion and RD #105 indicated that this resident was on this identified diet due a different reason than resident #007 and resident #004. RD #105

could not provide information on resident #007's plan of care related to their nutritional risk.

ADOC #106 was interviewed and stated that there would be several factors into why a resident would be placed on the identified diet. ADOC #106 referred to the dietary assessments from RD #105 on PointClickCare (PCC) related to resident #007 to identify whether they had the identified nutritional risk. Inspector #760 asked whether the home's PSWs would be able to access this information and ADOC #106 stated this information would be communicated to the PSWs through a verbal report from the registered staff. ADOC #106 could not produce information on resident #007's plan of care related to their nutritional risk.

The home failed to ensure that resident #004 and resident #007's plan of care related to their nutritional status included their nutritional risk. [s. 26. (3) 13.]

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 a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 13. Nutritional status, including height, weight and any risks relating to nutrition care., to be implemented voluntarily.

Issued on this 22nd day of July, 2020

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

Original report signed by the inspector.