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
Mar 17, 2021	2021_838760_0009	023643-20, 023803-20, 002509-21	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), SAMI JAROUR (570)

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 9, 10, 11, 12, 15, 2021.

The following intakes were completed in this complaints inspection:

One log was related to hospitalization and a change in condition;

One log was related to a bed refusal;

A follow up log to Compliance Order (CO) #001, O. Reg. 79/10 s. 229. (4), related to infection prevention and control, issued under inspection #2020_823653_0022, on November 24, 2020, with a compliance date of December 18, 2020, was inspected.

A Critical Incident Systems inspection #2021_598570_0008 was conducted concurrently with this Complaints inspection.

NOTE: A Written Notification and Voluntary Plan of Correction related to LTCHA, s. 6 (7) was identified in a concurrent inspection #2021_598570_0008 and issued in this report.

During the course of the inspection, the inspector(s) spoke with Physiotherapist (PT), Registered Dietitian (RD), Dietary Services Supervisor, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Infection Prevention and Control Lead, the Administrator and the interim Director of Care (DOC).

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Infection Prevention and Control
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)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 229. (4)	CO #001	2020_823653_0022	760

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #007's plan of care was followed related an intervention from the registered dietitian (RD).

The Ministry of Long-Term Care was informed of concerns related to the resident's care. The resident had a significant change in their condition when they were hospitalized. A review of the resident's chart indicated they had a change in their nutritional status on the day prior to their hospitalization. The RD had assessed the resident the day before they went to the hospital and provided an intervention related to their nutritional status. The documentation did not indicate if the resident had received this intervention. A number of registered staff who had worked with the resident did not recall providing the resident with this intervention. The RD stated that on the day before the resident was hospitalized, they should have received the intervention they had recommended, in accordance with the assessment they made and the resident's condition at that time. There was potential risk to the resident, as it may have been beneficial to the resident related to their condition prior to the hospitalization to have received a nutritional intervention to improve their status.

Sources: Review of the resident's progress notes, electronic and paper chart; Interviews with the RD and other staff. (760) [s. 6. (7)]

2. The licensee has failed to ensure that resident #003's plan of care was provided to the resident as specified in the plan.

The MLTC received a Critical Incident Systems (CIS) report regarding resident #003, who sustained a fall. An observation was conducted by the inspector and the resident told them that they did not use a fall prevention intervention. Record review of the current plan of care for the resident indicated that they did have that fall prevention intervention. A PSW and RPN both confirmed that the resident did not have their fall prevention intervention in place. Interviews with the RPN, Physiotherapist (PT) and interim Director of Care (DOC), indicated the resident should have their fall prevention intervention in place, as it is part of their written plan of care. By not ensuring resident #003's plan of care was provided to the resident as specified in the plan, they were placed at risk of not having their needs met as required.

Sources: Plan of care for resident #003, interviews with resident #003, a PSW, an RPN, the PT and the interim DOC. (570) [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 18th day of March, 2021

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

Original report signed by the inspector.