Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
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Original Public Report

Report Issue Date: June 3, 2024
Inspection Number: 2024-1052-0003
Inspection Type: Critical Incident Follow up
Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.
Long Term Care Home and City: Rockcliffe Community, Scarborough

Lead Inspector	**Inspector Digital Signature**
Matthew Chiu (565)	Matthew Chiu Digitally signed by Matthew Chiu Date: 2024.06.03 15:31:58 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 8, 13-17, and 21-24, 2024.

The following intake(s) were inspected:
• #00111670 related to infectious disease outbreaks;
• #00109803 related to follow-up of compliance order #001 from inspection #2024-1052-0002;
• #00110777; #00111278; #00113214 related to prevention of abuse and neglect.

The following intake was completed:
• #00109001 related to infectious disease outbreaks.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1052-0002 related to O. Reg. 246/22, s. 93 (2) (b) inspected by Matthew Chiu (565)

The following **Inspection Protocols** were used during this inspection:

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee has failed to ensure that resident #003's right to be treated with courtesy and respect was fully respected by a personal support worker (PSW).

Rationale and Summary:
Record review and staff interviews identified a PSW provided care to resident #003 in a rough manner. The resident reported that the PSW was rough during the care. Additionally, a registered practical nurse (RPN) witnessed the care and noted that the PSW performed it hurriedly, without proper explanation or observation of the resident's response. As a result, the resident experienced pain during the care.

The RPN stated that the PSW should have treated the resident with courtesy and respect, including explaining the procedure, observing the resident's responses, and providing care at an appropriate pace. These steps were not followed. The director of care (DOC) acknowledged that resident #003's right to be treated with courtesy and respect was not fully respected by the PSW during this care.

The licensee has failed to ensure that resident #003 was treated with courtesy and respect which compromised the resident's well-being, dignity, and rights.

Sources: Progress notes, investigation records; interviews with resident #003, the PSW, RPN, and DOC.
[565]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
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.

The licensee has failed to ensure that the care set out in resident #002's behavioural plan of care was provided to the resident as specified in the plan.

Rationale and Summary:
Record review revealed that resident #002 had a history of responsive behaviours, and their plan of care set out a specified care for managing these behaviours. During a shift, resident #002 exhibited these behaviours in the presence of a PSW. The PSW did not provide the specified care to the resident, resulting in the escalation of the resident's behaviours. The DOC confirmed that the PSW should have provided the care as specified in the plan.

Failure to provide resident #002 with the care as specified in their plan of care increased the risk of exacerbating the resident's behaviours and compromising both their well-being and safety.

Sources: Resident's care plan, progress notes, home's investigation records; interviews with the PSWs, registered nurse (RN), and the DOC.
[565]

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
s. 24 (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.

The licensee has failed to ensure that resident #002 was protected from physical abuse by a PSW.

Rationale and Summary:

For the purposes of the definition of "abuse", "physical abuse" means the use of physical force by anyone other than a resident that causes physical injury or pain to a resident.

Record review and staff interviews revealed that on a specified date, a PSW engaged in an incident with resident #002 in the resident's room. Two staff members witnessed the PSW hitting the resident during the incident, resulting in the resident experiencing pain. The DOC acknowledged that resident #002 was not protected from physical abuse by the PSW.

The licensee failed to ensure that resident #002 was protected from physical abuse, resulting in the resident experiencing pain.

Sources: Resident's progress notes, home's investigation records, incident form; interviews with the resident, PSW, RN, resident & family experience coordinator (RFC), and the DOC.
[565]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that on every shift, symptoms of infectious disease were recorded for resident #004.

Rationale and Summary:
Record review and staff interview revealed that on a specified date, resident #004 began demonstrating symptoms of an infectious disease and was subsequently placed under droplet contact precautions. Interview with the infection prevention and control (IPAC) lead indicated that staff were required to monitor the resident's symptoms of infection during every shift and document them in Point Click Care (PCC). However, during one shift, there was no recorded documentation of the resident's symptoms.

The failure to record symptoms of infection every shift may increase the risk of ineffective care planning and potential of delayed interventions for resident #004.

Sources: Resident's progress notes, assessment records; interview with the IPAC lead.
[565]