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
Dec 23, 2019	2019_575214_0038	020098-19	Complaint

Licensee/Titulaire de permis

Rykka Care Centres LP
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

Long-Term Care Home/Foyer de soins de longue durée

Orchard Terrace Care Centre
199 Glover Road STONEY CREEK ON L8E 5J2

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

CATHY FEDIASH (214)

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): December 12, 13, 16, 2019.

Please note: This inspection was conducted simultaneously with critical incident system (CIS) inspection # 2019_575214_0037 / 013860-19, 020038-19.

The following intake was completed during this complaint inspection:

-020098-19: related to prevention of abuse and neglect; skin and wound.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED); Director of Care (DOC); Program Manager; Resident Assessment Instrument (RAI) Coordinator; Registered Nurses (RN's); Registered Practical Nurses (RPN's); Personal Support Workers (PSW's); residents and family members.

During the course of the inspection, the inspector(s) reviewed the complaint; resident clinical records; relevant policy and procedures; home's investigative notes; training records; program evaluations and observed residents.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in resident #001's plan of care was based on an assessment of their needs and preferences.

A review of complaint log #020098-19 and CIS log #020038-19, indicated that on an identified date and time, resident #001 required specified care. During care, it was reported by PSW staff #103 that resident #001 demonstrated identified responsive behaviour's toward PSW staff #105 and staff #105 then demonstrated an identified action toward the resident.

A review of the resident's clinical records indicated a responsive behaviour assessment, dated with an identified date, had been conducted. The assessment indicated the resident demonstrated specified behaviours and included identified triggers and interventions.

A review of the resident's plan of care indicated the care plan document contained a focus of the potential for the resident to demonstrate the behaviour, including specified actions toward staff. The care plan document also identified the triggers and interventions identified in the assessment; however, this focus had been initiated 34 days following the date of the assessment and 13 days following the date of the CIS.

During an interview with the ED and the DOC, it was confirmed that resident #001's plan of care in relation to their responsive behaviours, had not been based on their assessed needs and preferences, for the time periods identified. [s. 6. (2)]

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 based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

WN #2: 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:
17. Drugs and treatments. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001's plan of care was based on an interdisciplinary assessment of the resident's drugs and related safety risks.

A review of complaint log #020098-19 and CIS log #020038-19, indicated that on an identified date and time, resident #001 required specified care. During care, it was reported by PSW staff #103 that resident #001 demonstrated identified responsive behaviour's toward PSW staff #105 and staff #105 then demonstrated an identified action toward the resident.

A review of identified progress notes, indicated the resident had been assessed by RPN #106, to have identified alterations to their skin integrity to specified areas on their body.

Review of an identified progress note documented by the Nurse Practitioner (NP), indicated they had been present during the skin assessment and that the resident had been taking specified, prescribed drugs.

Interviews with the ED; DOC; RPN staff #106 and RN staff #104 and #109, indicated that the resident was prone to specified alterations to their skin integrity in relation to the specified, prescribed drugs.

Review of the resident's current, electronic Medication Administration Record (e-MAR), indicated the resident was prescribed drugs known to have the potential to alter their skin integrity.

A review of the resident's plan of care from admission to the date of this inspection, had not identified the use of these drugs or their associated safety risks, including the risk of specified, altered skin integrity.

During an interview with the ED and DOC, it was confirmed that resident #001's plan of care plan had not been based on an interdisciplinary assessment of the resident's drugs identified above, including the safety risks associated with these drugs. [s. 26. (3) 17.]

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 plan of care is based on, at a minimum, interdisciplinary assessment of the resident's drugs and safety risks, to be implemented voluntarily.

Issued on this 31st day of December, 2019

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

Original report signed by the inspector.