Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 25, 2020	2020_836766_0011	003649-20, 004082-20, 010189-20, 011036-20, 011391-20, 016812-20	Critical Incident System

Licensee/Titulaire de permis

Corporation of the County of Grey
595 9th Avenue East OWEN SOUND ON N4K 3E3

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

Rockwood Terrace Home for the Aged
575 Saddler Street East P.O. Box 660 DURHAM ON N0G 1R0

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

KATY HARRISON (766), SHARON PERRY (155)

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): August 17-21, 2020

During the course of this inspection the following intakes were inspected:

Log #003649-20, CI #M570_000008_20 related to an unexpected death.

Log #004082-20, CI #M570_000009_20 related to an unexpected death.

Log #010189-20, CI #M570_000010_20 related to incompetent treatment or care.

Log #001391-20, CI #M570_000013_20 related to an unexpected death.

Log #011036-20, CI #M570_000012_20 related to a fall.

Log #016812-20, CI #M570-000015-20 related to an unexpected death.

The inspector toured resident home areas, observed resident care provision, resident staff interaction; reviewed relevant clinical records, policies and procedures pertaining to the inspection.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse (RPN) and Personal Support Workers (PSW).

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #001.

A Critical Incident was submitted related to an incident that resulted in an injury to resident #001. The report stated that on a certain date resident #001 was being transferred unsafely which lead to an injury

The progress notes showed that the residents condition continued to deteriorate following the incident. The physician was notified, an X-ray was ordered. The X-ray confirmed a fracture.

PSW #103 stated that all staff were aware of the correct procedure for transferring residents. RPN #102 confirmed that staff should have used the appropriate transfer technique. DOC #101 acknowledged that the transfer was not safe.

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #001. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 27th day of August, 2020

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

Original report signed by the inspector.