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_0037	013860-19, 020038-19	Critical Incident System

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): December 12, 13, 16, 2019.

Please note: This inspection was conducted simultaneously with complaint inspection #2019_575214_0038 / 020098-19.

The following intakes were completed during this CIS inspection:

-020038-19: related to prevention of abuse and neglects; skin and wound.
-013860-19: related to personal support services.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED); Director of Care (DOC); Registered Nurses (RN's); Personal Support Workers (PSW's).

During the course of the inspection, the inspector(s) reviewed the Critical Incident Systems; resident clinical records; relevant policy and procedures; home's investigative notes; staff training records and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
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 failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #006.

A CIS was submitted to the Ministry of Long Term Care (MOLTC), under an identified category. The CIS indicated that on an identified date, PSW staff #103 and #104 were preparing to transfer #006. It was reported that while PSW staff #104 reached for an identified item, PSW staff #103 performed the transfer of the resident on their own. As a result, the resident required repositioning. The resident sustained alterations to their skin integrity to an identified area on their body. The CIS indicated it was unclear if the altered skin integrity occurred during the transfer or repositioning of the resident.

A review of the quarterly, Minimum Data Set (MDS) assessment dated with an identified date, indicated the resident was coded for this specified care as requiring an identified level of assistance, with a specified quantity of staff. The corresponding narrative Resident Assessment Protocol (RAP), indicated that the resident required the same identified level of assistance with all activities of daily living (ADL).

A review of an identified assessment dated the day following the incident, indicated that the resident was assessed to still require the same level of assistance with the same specified quantity of staff, for this specified care need.

A review of the resident's care plan indicated that at the time this specified care was provided, the resident was to receive the assessed level of assistance with a specified quantity of staff to be present for completion of the specified care.

The DOC confirmed during an interview, that transferring and positioning techniques had not been provided safely to resident #006. [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 assiting residents, 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.