Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 14, 2016	2016_216144_0035	015926-16	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE SOUTHWOOD LAKES
1255 NORTH TALBOT ROAD WINDSOR ON N9G 3A4

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

CAROLEE MILLINER (144), ALISON FALKINGHAM (518), TERRI DALY (115)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): May 31, June 1, 2, 3, 6, 7, 8, 2016.

During the Resident Quality Inspection (RQI), the following Critical Incident Inspections were completed:
#015415-15 related to misuse/misappropriation of resident's money
#001092-15 related to resident to resident abuse
#007602-16 related to a fall with transfer to hospital
#015464-15 related to a fall with transfer to hospital
#007602-16 related to a fall with transfer to hospital

During the course of the inspection, the inspector(s) spoke with 40+ residents, four family members, the Administrator, Director of Care, Nutrition Manager, Registered Dietitian, Social Worker, Maintenance Supervisor, Office Supervisor and one Registered Nurse (RN), six Registered Practical Nurses (RPN), fourteen Personal Support Workers (PSW) and one Housekeeping Aide (HA).

During the course of the inspection, the Inspector(s) toured all resident home areas, one medication room, observed medication administration, dining service, provision of care, recreational activities, resident/staff interactions, infection control prevention and control practices, reviewed residents clinical records, posting of required information, meeting minutes related to the inspection and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **3 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	Legendé 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The Licensee failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall
immediately report the suspicion and the information upon which it is based to the Director:
Abuse of a resident by anyone or neglect of a resident by the licensee of staff that resulted in harm or risk of harm to the resident.

An incident of resident to resident abuse occurred between two residents which resulted in a minor injury to one resident. The resident was removed from the area, had an assessment completed and the area of injury addressed.

Critical Incident report #2842-000003-15 was submitted to the Director of the Ministry of Health and Long Term Care (MOHLTC) three days post incident.

The DOC #105 said the Social Worker/ Manager #139 on call at the time of the incident, was immediately notified by telephone of the occurrence by the charge nurse.

The home's policy Mandatory and Critical Incident Reports RC-11-01-06, last revised April 2016 under procedures states the Director of Care and Designate will inform the MOH Director immediately, in as much detail as is possible in the circumstances of each of the following incidents in the home:

Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to a resident

The Administrator #100 and Director of Care #105 said that the home submitted the critical incident three days late and verified the home's expectation was that all incidents of resident to resident abuse are reported to the Director of the MOHLTC within the required reporting parameters. [s. 24. (1)]

2. A witnessed incident of resident to resident abuse occurred on an alternate date.

Critical Incident report #2842-000019-15 was submitted to the Director of the MOHLTC three days post incident.

The home's policy Mandatory and Critical Incident Reports RC-11-01-06, last revised April 2016 under procedures Director states the Director of Care and Designate will inform the MOHLTC Director immediately, in as much detail as is possible in the circumstances, of each of the following incidents in the home:
Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to a resident

The DOC #105 said the Social Worker/Manager #139 on call at the time of the incident, was immediately notified by telephone of the occurrence by the charge nurse.

The Administrator #100 and Director of Care #105 said that the home submitted this critical incident three days late and verified the home's expectation was that all incidents of resident to resident abuse are reported to the Director of the MOHLTC within the required reporting parameters. [s. 24. (1)]

3. One resident reported concerns to the Social Worker. The Social Worker noted the discrepancies the resident spoke of and was advised by the Administrator #100 to contact the Citizen's Advocacy Group.

A Critical Incident report #2842-000011-15 was submitted to the MOHLTC ten days post incident.

The home's policy Mandatory and Critical Incident Reports RC-11-01-06, last revised April 2016 under procedures states the Director of Care and Designate will inform the MOHLTC Director immediately, in as much detail as is possible in the circumstances, of

identified specific incidents in the home which included the resident's concerns.

The Administrator #100 said that the home submitted this critical incident once they had completed their investigation and said that the resident's concerns were verified.. A review of the legislation with the Administrator revealed a "suspected" incident should be reported immediately to the Director of the MOHLTC.. [s. 24. (1) 4.]

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 a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The Licensee failed to ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
An injury in respect of which a person is taken to the hospital

One resident was observed being in an unusual position near activity room. The resident complained of pain and a minor injury was noted. The resident was assessed and the injury addressed. One of the home's policies was initiated.

Later in the day, the resident complained of increased pain and was transferred to hospital. The resident returned to the nursing home with a treatment plan in place and continues to require additional assistance with activities of daily living.

The home's policy Mandatory and Critical Incident Reports RC-11-01-06, last revised April 2016 under procedures states the Director of Care and Designate will inform the MOH Director no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

Critical Incident report #2842-00001 regarding this incident was not submitted to the MOHLTC until two days after the incident.

The Administrator #100 and Director of Care #105 said that the home submitted this critical incident one day late and verified the home's expectation was that all resident's with injuries that are transported to hospital and have had a change in their health condition should be reported to the Director of the MOHLTC in one day. [s. 107. (3) 4.]

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 o ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection 4, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

One resident's washroom was observed by one Inspector on three occasions during the Resident Quality Inspection. During the three observations, a topical prescription medication was present on the bathroom counter. RPN #126 agreed the prescription cream was on the washroom counter and said that in order for residents to keep and use medications in their room the medication must be in a locked area and the physicians orders and care plan must reflect this.

Review of the physician orders for this resident revealed the date the medication was ordered and discontinued. There was no indication in the order that the resident may use this medication on their own or keep it in their room. The resident's plan of care did not reflect the resident had the ability to use the medication independently.

The home's policy 11-23 last revised September 2010 states that residents are permitted to self administer medications only when a physician or nurse practitioner has written an order in the resident's heath record, the resident must be capable of making their own health care decisions and the medication must be kept in a locked place away from other residents.

The Director of Care #105 stated that this medication should not have been in the resident's washroom and the home's expectation was that all residents who self administer medication have a proper physician's order indicating self use, that the medication is kept in a locked area and the care plan reflects the self use of the medication. [s. 131. (5)]

Issued on this 14th day of June, 2016

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

Original report signed by the inspector.