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 |
|---|---|---|---|
| Jul 4, 2017 | 2017_538144_0022 | 006196-17 | Complaint |

## 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)

## 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): May 17 and 18, 2017**

**This complaint related to falls prevention and management.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing, one Registered Nurse, one Registered Practical Nurse and maintenance personnel.**

**One resident clinical record was reviewed.**

**The following Inspection Protocols were used during this inspection:**
**Minimizing of Restraining**
**Personal Support Services**

**During the course of this inspection, Non-Compliances were issued.**
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the written plan of care for one resident set out clear directions to staff and others who provide direct care to the resident.

The Administrator and maintenance personnel told the Inspector that the bed system for one resident was changed on a specified date.

The clinical record for the resident stated that one bed rail on the resident's previous bed was removed. On the date of this inspection, the Inspector observed two bed rails in the elevated position on the resident's bed.

The current care plan for the resident did not include the use of the bed rails in use

The Administrator and Director of Nursing acknowledged that the resident's bed rails should be included in the resident's care plan to provide clear direction to staff.

The licensee failed to ensure that the plan of care for one resident set out clear directions related to resident bed rail use.

The severity of this issue was determined to be level one as there was minimal risk. The scope was isolated during the course of this inspection. The home has a history of previous unrelated areas of non-compliance. [s. 6. (1) (c)]

***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 written plan of care for one resident set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails**

**Specifically failed to comply with the following:**

**s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,**
**(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).**
**(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).**
**(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that where bed rails are used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

The Substitute Decision Maker for one resident, the Administrator and maintenance personnel explained that the resident’s bed system was upgraded on a specified date.

The resident's clinical record on review did not include a bed rail assessment.

Maintenance personnel said that the new bed system for the resident passed the evaluation when it was completed and that the evaluation of the bed system was not documented.

The Administrator and one RPN  said that the resident was not assessed for bed rail use with their new bed system and that registered staff do not complete assessments of residents that use bed rails with their bed.

The licensee failed to ensure that where bed rails were used, the resident was assessed.

The severity of this issue was determined to be level one as there was minimal risk. The scope was isolated during the course of this inspection. There was a compliance history of this regulation being issued as a Written Notification (WN) on September 2, 2014. [s. 15. (1) (a)]

**Issued on this 4th day of July, 2017**

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

**Original report signed by the inspector.**