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 21, 2017	2017_418615_0014	009040-17	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

HELENE DESABRAIS (615), ANDREA DIMENNA (669)

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 15, 16, 17, 18 and 19, 2017.

The following intake was completed during this inspection:
029819-16/2842000006-16, Critical Incident related to Prevention of Abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Clinical Coordinator (CC), the Recreation Manager, the Maintenance Supervisor, the Registered Practical Nurse - Resident Assessment Instrument (RPN-RAI Coordinator), five Registered Practical Nurses, eight Personal Support Workers, the Family Council representative, over 20 residents and three family members.

Inspectors also toured the residents' home areas and common areas, spa rooms, observed resident care provision, resident/staff interactions, medication administration and storage areas, reviewed relevant clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection, and observed general cleaning of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
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	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A review of a resident's Minimum Data Set (MDS) assessment, on a specific date, stated the resident's continent status and the resident's care plan included interventions for their continent status.

A review of the resident's paper chart included one incontinence assessment, however no other continence assessments were completed.

During an interview, a RPN-RAI Coordinator, a RPN and a PSW stated that the resident's continence status had changed when returning from the hospital. The RPN-RAI Coordinator said that the resident was not assessed for continence with their change in status.The RPN-RAI Coordinator stated that when a change occurs in a resident's continence, they are to be assessed so that proper products can be used for their care.

During an interview, the DOC shared that when a resident's continence was declining they were assessed with the three day monitoring tool, to determine product use for the resident. The DOC acknowledged that the resident was not assessed for bladder and bowel incontinence when a change occurred and that the home’s expectation was for this assessment to be completed.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was determined to be isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on June 2, 2016, as a Voluntary Plan of Correction (VPC) on a Complaint Inspection #2016_216144_0036, September 2, 2014, as a VPC on a Resident Quality Inspection #2014_216144_0044 and, August 15, 2014, as a VPC on a Complaint Inspection #2014_256517_0039. [s. 6. (10) (b)]

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 resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The home has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that the following were documented: 1. The

circumstances precipitating the application of the physical device. 2. What alternatives were considered and why those alternatives were inappropriate. 3. The person who made the order, what device was ordered, and any instructions relating to the order. 4. Consent. 5. The person who applied the device and the time of application. 6. All assessment, reassessment and monitoring, including the resident’s response. 7. Every release of the device and all repositioning. 8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

On three specific dates, Inspectors observed a resident utilizing an assistive device with a specific intervention and unable to use the device when trying.

On a specific date, an Inspector observed the resident with the assistive device, without the specific intervention and the ability to use it.

A review of the home's "Physical Restraint" policy #RESI-10-01-01 dated November 2012, stated "Any manual method, or any physical or mechanical device, material, or equipment, that is attached or adjacent to the person's body, that the person cannot remove easily, and that does, or has the potential to restrict the resident's freedom of movement or normal access to his/her body. It is the effect the device has on the resident that defines it as a restraint, not the name or label given to the device, nor the purpose or intent of the device".

A review of the Occupational Therapy Note, on a specific date, stated that the resident “continues to use the assistive device”, and on a different date stated that the resident had a change in status and was using the assistive device with the specific intervention.

A review of the resident’s clinical record had no documented evidence or physician's order for the use of the assistive device with a specific intervention.

During an interview, on a specific date, an RPN stated that the resident used the assistive device and was able to get up. The RPN stated that the reason the resident used the assistive device with a specific intervention was to relieve pressure and that the intervention should only be 15 minutes at a time. The RPN acknowledged that there was no physician's order or documented evidence to support the use of the assistive device with the specific intervention for this resident.

During an interview, on a specific date, a PSW stated that the resident’s assistive device and the specific intervention was to prevent the resident from getting up and falling, that

there was a physician's order for the use of the assistive device and specific intervention and applied when the nurse was requesting it.

During an interview, on a specific date, two other PSWs, both stated that when the resident is using the assistive device, the specific intervention should not be used because the resident was able to use the device most of the time.

During interviews with the DOC and the RPN-RAI Coordinator, both acknowledged that there was no documented evidence to support the use of the specific intervention for the resident's assistive device and that using that specific intervention was a restraint for the resident.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was determined to be isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 110. (7)]

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 every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, to ensure that the following are documented: 1. The circumstances precipitating the application of the physical device. 2. What alternatives were considered and why those alternatives were inappropriate. 3. The person who made the order, what device was ordered, and any instructions relating to the order. 4. Consent. 5. The person who applied the device and the time of application. 6. All assessment, reassessment and monitoring, including the resident's response. 7. Every release of the device and all repositioning. 8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care, to be implemented voluntarily.

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Issued on this 11th day of July, 2017

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

Original report signed by the inspector.