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
Aug 4, 2021	2021_791739_0030	009481-21, 011145-21	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 Markham ON L3R 4T9

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

JULIE DALESSANDRO (739)

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): July 20, 21, 22, 23, 26, 27, 28, and 29, 2021

During the course of this inspection the following intakes were completed:
Log #011145-21 related to infection prevention and control
Log #009481-21 related to personal support services

During the course of the inspection, the inspector(s) spoke with Personal Support Worker(s), Registered Nurse(s), the Nurse Practitioner, and the Director of Nursing.

During the course of this inspection the inspector(s) also conducted observations and record review relevant to the inspection.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
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. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

The licensee had failed to ensure that resident #001 and #003's symptoms of infection were monitored every shift.

A) Record review of resident #001's progress notes in Point Click Care (PCC) indicated that they were exhibiting signs of infection. Record review of resident #001's progress notes and temperature monitoring log in PCC showed that symptoms of infection were not monitored every shift.

B) Record review of resident #003's progress notes in PCC indicated that they were on an antibiotic for an infection. Record review of resident #003's progress notes and temperature monitoring log in PCC showed that symptoms of infection were not monitored every shift.

During an interview with RN #101, they stated that resident's with signs of infection should have been monitored at least once a shift.

During interviews with the home's Director of Nursing and Infection Control Nurse they stated that the expectation would have been that symptoms were monitored every shift and acknowledged that this was not completed for resident #001 and #003.

Not monitoring for symptoms of infection put resident's at risk for worsening health conditions.

Sources: Progress notes in PCC, temperature monitoring in PCC, interviews with RN #101, the DOC and the Infection Control Nurse.

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 symptoms indicating the presence of infection in residents are monitored every shift, to be implemented voluntarily.

Issued on this 4th day of August, 2021

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

Original report signed by the inspector.