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

London Service Area Office
130 Dufferin Avenue 4th floor
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 26, 2021	2021_747725_0039	012137-21, 013075-21, 014116-21, 014296-21, 015172-21, 018053-21	Critical Incident System

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

CASSANDRA TAYLOR (725), MELANIE NORTHEY (563)

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): November 15-18, 2021.

This inspection was conducted concurrently with complaint inspection #2021_747725_0040

The purpose of this inspection was to inspect of the following intakes;
Log #012137-21/ CIS 2842-000039-21 relating to resident to resident responsive behaviours
Log #014116-21/ CIS 2842-000046-21 relating to resident to resident responsive behaviours
Log #015172-21/ CIS 2842-000050-21 relating to resident to resident responsive bahaviours
Log #014296-21/ CIS 2842-000047-21 relating to falls prevention and management
Log #013075-21/ CIS 2842-000041-21 relating to falls prevention and management
Log #018053-21/ CIS 2842-000054-21 relating to a facility outbreak

During the course of the inspection, the inspector(s) spoke with The Administrator, the Director of Care, the Clinical Coordinator, one Registered Nurse, four Registered Practical Nurses, five Personal Support Workers, one Social Worker, one Dietary Manager, one Dietary Aide, one housekeeping staff, residents and families.

During the course of the inspection inspector(s) also observed infection prevention and control measures, dining services, general staff to resident interactions and record review relevant to the inspection.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **3 WN(s)**
- **2 VPC(s)**
- **1 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. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a plan to provide for a staffing mix that was consistent with residents' assessed care and safety needs.

On an evening of November 2021, the home had two Personal Support Workers (PSW) not show for their shift on the first floor and one PSW called in sick on another unit on the first floor. The home was cohorting the floors due to an outbreak. Review of the homes staffing plan did not account for cohorting of staff during an outbreak. Leaving three PSW, two Registered Practical Nurses (RPN) and one Registered Nurse (RN) on the main floor for three units.

Resident #008 and #009 reported to the inspector that they were not offered a dinner meal on that evening in November 2021. Resident #012 reported to the inspector that they were not assisted with care as required at bedtime on that evening of November 2021. During record review all records for that date in November 2021, evening shift, care and meal services were blank for a specific unit.

During an interview with the RN they confirmed they were short staffed. The RN could not confirm or deny if any residents on the specific unit had missed their meals.

During an interview with the Director of Care (DOC), they could not confirm or deny that the residents on the specific unit received their snacks, dinner or care services as planned. The DOC acknowledged that the staffing plan did not meet the care and documentation need of the residents.

Not having a plan to support unexpected staffing shortages placed residents at increased risk to miss planned care and services.

Sources: Resident interviews with resident #008, #009 and #012, staff interviews with the RN and DOC. The specific unit resident record review and staff schedule. [s. 31. (3)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #005 and #008 were bathed at a minimum, twice a week by the method of their choice, unless contraindicated by a medical condition.

On review of Resident #005's care record it indicated that the resident had missed one bath weekly for two weeks in a row, with no documentation to support a substitute bath had occurred.

On review of Resident #008's care record it indicated that the resident has missed a bath on a day in November, with no documentation to support a substitute bath had occurred. Resident #008 confirmed they did not receive a make up bath.

The DOC confirmed that expectation would be that residents receive two baths per week or as directed and that a make up bath be completed if a scheduled bath was missed.

Not completing the minimum required two baths per week placed resident #005 and #008 at risk for personal hygiene issues.

Sources: Resident #005 and #008's records, resident #008 interview and staff interview with the DOC. [s. 33. (1)]

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 residents #005, #008 and all other residents are bathed at a minimum, twice a week by the method of their choice, to be implemented voluntarily.

WN #3: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were offered the opportunity to complete hand hygiene prior to and after meals.

Observations were completed on a date in November 2021, of the lunch service on a specific unit. No residents were observed to have completed or been offered to complete hand hygiene prior to the meal service. After the meal service was over it was observed that residents that were visibly soiled were assisted to clean up. However no other residents were offered the opportunity to complete hand hygiene.

Observations were completed on a date in November 2021, of the dinner service on a specific unit. No residents were observed to have completed or been offered to complete hand hygiene prior to or after the meal service.

The Clinical Coordinator (CC) indicated that resident should be offered the opportunity to complete hand hygiene prior to and after meals.

Not offering the residents the opportunity to complete hand hygiene prior to and after meals placed the residents at risk for possible spread of infection.

Sources: Lunch observation, Dinner observation and staff interview with CC. [s. 229. (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 residents are offered the opportunity to complete hand hygiene prior to and after meals, to be implemented voluntarily.

Issued on this 26th day of November, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	CASSANDRA TAYLOR (725), MELANIE NORTHEY (563)
Inspection No. / No de l’inspection :	2021_747725_0039
Log No. / No de registre :	012137-21, 013075-21, 014116-21, 014296-21, 015172-21, 018053-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 26, 2021
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, Markham, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Southwood Lakes 1255 North Talbot Road, Windsor, ON, N9G-3A4
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Matthew Summerfield

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Order / Ordre :

Specifically the licensee must;

A.Review and revise their staffing plan to meet the care needs and services of the residents during an unexpected staffing shortage.

B. Review and revise the staffing plan to meet the care needs and services of the residents during a staffing shortage during a potential outbreak.

C.Educate all On-Call managers on their role in the staffing plan during a staffing shortage.

D.Educate all registered staff on how to initiate the staffing shortage plan.

E. Communicate the staffing shortage plan to the resident and family councils.

Grounds / Motifs :

1. The licensee has failed to ensure that there was a plan to provide for a

staffing mix that was consistent with residents' assessed care and safety needs.

On an evening of November 2021, the home had two Personal Support Workers (PSW) not show for their shift on the first floor and one PSW called in sick on another unit on the first floor. The home was cohorting the floors due to an outbreak. Review of the homes staffing plan did not account for cohorting of staff during an outbreak. Leaving three PSW, two Registered Practical Nurses (RPN) and one Registered Nurse (RN) on the main floor for three units.

Resident #008 and #009 reported to the inspector that they were not offered a dinner meal on that evening in November 2021. Resident #012 reported to the inspector that they were not assisted with care as required at bedtime on that evening of November 2021. During record review all records for that date in November 2021, evening shift, care and meal services were blank for a specific unit.

During an interview with the RN they confirmed they were short staffed. The RN could not confirm or deny if any residents on the specific unit had missed their meals.

During an interview with the Director of Care (DOC), they could not confirm or deny that the residents on the specific unit received their snacks, dinner or care services as planned. The DOC acknowledged that the staffing plan did not meet the care and documentation need of the residents.

Not having a plan to support unexpected staffing shortages placed residents at increased risk to miss planned care and services.

Sources: Resident interviews with resident #008, #009 and #012, staff interviews with the RN and DOC. The specific unit resident record review and staff schedule.

An order was made taking the following factors into account;

Severity: Not having a plan to support unexpected staffing shortages placed residents at increased risk to miss planned care and services.

Scope: The scope of this issue was isolated to the events of the evening shift of a date in November 2021.

Compliance History: In the past 36 months non-compliance has been issued to the home related to different sub-sections of the legislation.

(725)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 17, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 26th day of November, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cassandra Taylor

Service Area Office /
Bureau régional de services : London Service Area Office