Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Inspection Report under the LTC Homes Act, 2007 ☒ Public Copy ☐ Licensee Copy	**Rapport d'inspection prevue de le Loi de 2007 les foyers de soins de longue durée** ☐ Copie du Titulaire ☐ Copie de la Publique	
Date(s) of inspection/Date de l'inspection August 5, 2010	**Inspection No/ d'inspection** 2010-155-2842-05Aug04319	**Type of Inspection/Genre d'insptection** Complaint L-00392

Licensee/Titulaire

Extendicare (Canada) Inc.
3000 Steeles Ave. 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(s)

Sharon Perry (#155), Terri Daly (#115)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection.

The inspection was conducted by two inspectors identified above.

The inspection occurred on August 5, 2010 with two inspectors being present on one day.

During the course of the inspection, the inspector(s) spoke with:
Administrator Susan Petahtegoose, Director of Care Kim Johnston, RN Krystal, RPN Anne, and resident.
The inspector(s) also did a review of resident records.

The following Inspection Protocols were used in part or in whole during this inspection:
Medication
Minimizing of Restraining
Hospitalization and Death

9 Findings of Non-Compliance were found during this inspection. The following action was taken:
9 WN
7 VPC

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Plan of correction/Plan de redressement
DR – Director Referral/Régisseur envoye
CO – Compliance Order/Ordres de conformité
WAO – Work and Acitvity Order/Ordres: travaux et activitiés

WN#1: The Licensee has failed to comply with: O. Reg. 79/10, s.131 (1).
The licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Findings:

1. Resident was administered Coumadin 3 mg by mouth on August 2, 2010 without this drug being prescribed.
2. Resident was readmitted to the home from hospital on August 2, 2010 however readmission orders or medication reconciliation was not completed until August 3, 2010. Home's medication reconciliation policy 10-8 reviewed and indicates to be done at time of readmission.

Further Inspector Actions:
VPC-pursuant LTCHA, 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 be implemented voluntarily.

Inspector ID#: 155 & 115
Required Compliance Date for WN: Immediate
Required Compliance Date for VPC: August 27, 2010

WN#2: The Licensee has failed to comply with: LTCHA, 2007, S.O. 2007, c.8,s.29(1)(a)(b).
The licensee of a long-term care home, shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and shall ensure that the policy is complied with 2007, c.8, s.29 (1).

Findings:

1. Resident was wearing a seatbelt restraint on August 5, 2010 and home did not ensure that their policy was complied with.

Further Inspector Actions:
VPC-pursuant LTCHA, 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 be implemented voluntarily.

Inspector ID#: 155 & 115
Required Compliance Date for WN: Immediate
Required Compliance Date for VPC: August 27, 2010

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

WN#3: The Licensee has failed to comply with: LTCHA, 2007, S.O. 2007, c.8,s.31(1)
A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31 (1).

Findings:
1. Plan of care for a resident did not include that a seatbelt restraint was to be utilized.

Further Inspector Actions:
VPC-pursuant LTCHA, 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 be implemented voluntarily.

Inspector ID#: 155 & 115
Required Compliance Date for WN: Immediate
Required Compliance Date for VPC: August 27, 2010

WN#4: The Licensee has failed to comply with: LTCHA 2007, S.O. 2007,c.8,s.31(2)4
The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied: A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.

Findings:
1. Resident was wearing a seatbelt restraint on August 5, 2010 and there was no order for use of the device.

Further Inspector Actions:
VPC-pursuant LTCHA, 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 be implemented voluntarily.

Inspector ID#: 155 & 115
Required Compliance Date for WN: Immediate
Required Compliance Date for VPC: August 27, 2010

WN#5: The Licensee has failed to comply with: LTCHA, 2007, S.O. 2007, c.8,s.31(2)5
The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied: The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Findings:
1. Resident has no consent for restraining and was found to be restrained with a seatbelt on August 5, 2010.
2. It was noted in the progress notes that on August 3, 2010 a resident's POA inquired with registered staff if there was an order for the seatbelt restraint as was concerned that it was too tight on abdomen. Registered staff placed a note in the report/communication book that there was no order and to monitor. It was also documented that Director of Care and Team Leader were informed.

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

Further Inspector Actions:
VPC-pursuant LTCHA, 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 be implemented voluntarily.

Inspector ID#: 155 & 115
Required Compliance Date for WN: Immediate
Required Compliance Date for VPC: August 27, 2010

WN#6: The Licensee has failed to comply with O.Reg. 79/10, s.110(2)1
The licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

Findings:
1. Resident was wearing a seatbelt restraint on August 5, 2010 and there was no order for use of the device.

Further Inspector Actions:
VPC-pursuant LTCHA, 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 be implemented voluntarily.

Inspector ID#: 155 & 115
Required Compliance Date for WN: Immediate
Required Compliance Date for VPC: August 27, 2010

WN#7: The Licensee has failed to comply with O.Reg. 79/10, s.110(7)4
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: Consent.

Findings:
1. Resident had no documented consent for the use of the seatbelt restraint.

Further Inspector Actions:
VPC-pursuant LTCHA, 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 be implemented voluntarily.

Inspector ID#: 155 & 115
Required Compliance Date for WN: Immediate
Required Compliance Date for VPC: August 27, 2010

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

WN#8: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8.s..6(1)(c)
Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings:

1. Resident was diagnosed with a right leg deep vein thrombosis and started on anticoagulation therapy. There was no written plan of care that set out clear directions to staff that provide direct care.
2. Resident returned from hospital on after having a gastro-intestinal bleed. There was no written plan of care that set out clear directions to staff that provide direct care.

Inspector ID#: 155 & 115
Required Compliance Date for WN: Immediate

WN#9: The Licensee has failed to comply with O.Reg. 79/10, s.26(3)10
A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Health conditions, including allergies, pain, risk of falls and other special needs.

Findings:

1. Resident was diagnosed with a right leg deep vein thrombosis and started on anticoagulation therapy. There was no written plan of care regarding this health condition.
2. Resident returned from hospital after having a gastro-intestinal bleed. There was no written plan of care regarding this health condition.

Inspector ID#: 155 & 115
Required Compliance Date for WN: Immediate

Signature of Licensee or Designated Representative Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
Title: Date:	Date of Report (if different from date(s) of inspection). August 17, 2010