Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prevue le *Loi de 2007 les foyers de soins de longue durée*

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

Toronto Service Area Office
55 St. Clair Avenue West, 8th Floor
Toronto ON M4V 2Y7

Telephone: 416-325-9297
1-866-311-8002
Facsimilie: 416-327-4486

Bureau régional de services de Toronto
55, avenue St. Clair ouest, 8e étage
Toronto ON M4V 2Y7

Téléphone: 416-325-9297
1-866-311-8002
Télécopieur: 416-327-4486

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Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
August 25, 2010	2010 144 2842Aug25104138	**Complaint #L-00049** **CI-282-000070-10**

Licensee/Titulaire
Extendicare (Canada) Inc.
300 Steeles Avenue, 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)

Carolee Milliner (#144)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection.

During the course of the inspection, the inspector spoke with the Administrator, RAI-MDS Coordinator & two (2) RPN's.

During the course of the inspection, the inspector reviewed the Home Abuse & Aggression Policy & the clinical records of two (2) identified residents.

The following Inspection Protocols were used in part or in whole during this inspection:
Responsive Behaviours
Skin & Wound

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

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

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

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 #1: The Licensee has failed to comply with LTCHA, 2007, S.O. s6(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. One resident experienced two skin tears within nine (9) days. The written plan of care does not set out clear directions to staff that provide direct care to manage the promotion of wound healing.
2. One resident physically assaulted a second resident resulting in a minor injury. The written plan of care does not set out clear directions to staff that provide direct care to manage physically aggressive behaviours.

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.
The plan of correction should ensure the written plan of care for each resident sets out, clear directions to staff & others who provide direct care to the resident.

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WN#2 The Licensee has failed to comply with LTCHA, 2007, S.O. s6(10)(b):
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, the resident's care needs change or care set out in the plan is no longer necessary

Findings:

1. The plan of care for one resident was not reviewed & revised when the resident's care needs changed with the expression of physically aggressive behaviour toward a second resident.

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WN#3 The Licensee has failed to comply with O. Reg. 79/10, s53(4)(a):
The licensee shall ensure that, for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, where possible

Findings:

1. The plan of care for one resident does not include behavioural triggers for responsive behaviours related to verbal & physical aggression.

Inspector ID# - 144

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Signature of Licensee or Representative of Licensee **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 25, 2010