



**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**

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

**London Service Area Office
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
Facsimile: (519) 675-7685**

**Bureau régional de services de
London
291, rue King, 4^{ième} étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685**

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 21, 2014	2014_216144_0014	L-000261-14	Critical Incident System

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

CAROLEE MILLINER (144)

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): March 18 and 20, 2014

**During the course of the inspection, the inspector(s) spoke with one resident,
the Acting Administrator, Acting Director of Care, one Registered Practical
Nurse, the Physiotherapist Assistant and two Personal Service Workers.**

**During the course of the inspection, the inspector(s) reviewed one critical
incident report, the home lifting/transfer logs and one resident clinical record.**

**The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management**



Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee of the home did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.
2. The clinical record for one resident confirms they were toileted by two staff 45 minutes before shift change.
3. On commencement of the new shift, a fire drill was conducted.
4. The staff assigned to check resident rooms and washrooms during the fire drill, confirmed to the Acting Administrator that they did not enter this resident's washroom during the drill as they didn't see a wheelchair in the room and assumed the resident was not present.
- 5 The resident rang the nurse call bell for staff assistance off the toilet 1.5 hours after being placed on the toilet.
5. Two management personnel and one staff confirmed the home protocol related to communication is to report to the oncoming shift that a resident remains on the toilet.
6. Two management personnel and one staff confirmed the home policy related to fire drills was not followed and staff did not check the residents washroom during the drill as required. [s. 8. (1) (a),s. 8. (1) (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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.



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Issued on this 21st day of March, 2014

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

CAROLEE MILLINER