Ontario

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, 4iém étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 19, 2014	2014_216144_0013	L-000256-14	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): March 18, 2014

During the course of the inspection, the inspector(s) spoke with one resident, the Acting Administrator, Acting Director of Care, one Registered Nurse and one Registered Practical Nurse.

During the course of the inspection, the inspector(s) reviewed one inquiry/intake report, one resident clinical record and two related home policies.

The following Inspection Protocols were used during this inspection:
Pain
Personal Support Services

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 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 identifies the resident has a cognitive performance scale and diagnosis effecting their cognitive functioning.
3. The resident is administered medication to assist with cognitive functioning.
4. The current quarterly review confirms the resident displays responsive behaviours.
5. The physician prescribed two medications to manage an infection and requested a referral to an external service provider.
6. The powers of attorney for the resident were not available to accompany the resident to the appointment with the external service provider.
7. The clinical record and one staff confirmed the powers of attorney were advised the home would make arrangements for transportation to and from the appointment and for an escort to accompany the resident.
8. The resident was transferred alone by a transportation service to and from the appointment. Two managers confirmed the driver of the transportation service does not stay with resident's during appointments.
9. The resident was absent from the home for the appointment longer than anticipated by the home.
10. When interviewed, the resident did not recall that they attended the external service provider appointment alone.
11. The clinical record, two managers and two staff confirmed the external service provider was unable to assess the resident as they were uncooperative and the appointment needed to be rescheduled with a family member at the resident's side.
12. Two managers confirmed the home did not follow their External Services policy requiring family or a volunteer to accompany residents for appointments outside the home.

13. One resident was prescribed prn medication by the physician for an infection.
14. The resident was administered the prn medication on several occasions during the period of review.
15. The reason for administration of the medication was not consistentley documented in the resident's clinical record.
16. One staff and two management personnel confirmed the home Medication Administration policy was not followed and that the reason for administration of prn medications. must be documented in the clinical record. [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.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee of a long term care home did not ensure that the home has a dining service that provides monitoring of all residents during meals.

2. The Inspector observed four residents in one dining room eating lunch without monitoring or supervision by staff.
3. One staff confirmed the home policy is that residents are not left alone when eating and that there was a staff assigned to remain in the ding room with residents on this date.
4. Two managers confirmed the dining rooms are not to be left unattended when residents are present and eating. [s. 73. (1) 4.]

Issued on this 19th day of March, 2014

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

CAROLEE MILLINER