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
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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
May 6, 2014	2014_216144_0022	L-000421-14	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): May 5, 2014

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

During the course of the inspection, the inspector(s) reviewed two resident clinical records and one home investigation summary

The following Inspection Protocols were used during this inspection:
Dining Observation
Prevention of Abuse, Neglect and Retaliation

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee did not ensure that the written plan of care for each resident sets out the planned care for the resident, the goals the care is intended to achieve and clear directions to staff and others who provide direct care to the resident.

a) The written plan of care for one resident does not include interventions currently in use to enhance the resident's communication skills.
b) One staff confirmed the above interventions are not included in the written plan of care. [s. 6. (1)]

2. The licensee did not ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

a) One resident is assessed as a high risk for falls.
b) The current written plan of care includes the use of a fall intervention when the resident is in bed.
c) On May 5, 2014, at 11:25 am and 1:15 pm, the item used for the intervention was not observed in the resident's room by Inspector #144.
d) Two staff confirmed a the intervention has not been used. [s. 6. (7)]

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 the written plan of care for each resident sets out the planned care for the resident, the goals the care is intended to achieve and clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: 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 did not ensure that any plan, policy, protocol, strategy or system the licensee is required to put in place, is complied with.

a) The call bell cord for one resident was not accessible on May 5, 2014 at 11:25 am.
b) The call bell was observed by two staff and Inspector #144 to be tangled and knotted around the left side rail of the bed with the end of the cord resting on the floor.
c) The home Communication Systems Policy directs staff to "ensure the call bell at the bedside is easily accessible to the resident at all times."
d) One management staff confirmed the home communication policy was not complied with. [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, strategy or system the licensee is required to put in place, is complied with, to be implemented voluntarily.

WN #3: 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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee did not ensure that proper techniques were used to assist residents with eating, including safe positioning of resident who require assistance.

- At 12:25 pm on May 5, 2014, one staff was observed in a standing position when feeding lunch to one resident.
- The resident's written plan of care identifies they are at high nutritional risk and has difficulty chewing.
- One RPN confirmed staff should be seated and at eye level with a resident during meal service when providing assistance to eat. [s. 73. (1) 10.]

Issued on this 6th day of May, 2014

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

CAROLEE MILLINER