Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Sep 24, 2013	2013_102116_0031	T-2166-12	Critical Incident System

Licensee/Titulaire de permis

SOUTHLAKE RESIDENTIAL CARE VILLAGE
640 GRACE STREET, NEWMARKET, ON, L3Y-2L1

Long-Term Care Home/Foyer de soins de longue durée

SOUTHLAKE RESIDENTIAL CARE VILLAGE
640 GRACE STREET, NEWMARKET, ON, L3Y-2L1

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

SARAN DANIEL-DODD (116)

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): July 26, 29, 30, 2013

Inspector attended the home to conduct an inspection of one critical incident (Log# T-2166-12) regarding resident drug regimes.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care and Registered staff members.

During the course of the inspection, the inspector(s) reviewed health records of residents, lab requisitions and the homes anticoagulant therapy policy (#11-10)

The following Inspection Protocols were used during this inspection:
Medication

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 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 :

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1. The licensee failed to ensure that there was a written plan of care for Resident #1 that sets out clear directions to staff and others who provided direct care to the resident.

- Resident #1 was admitted to the home with an order for administration of an anticoagulant drug. The homes policy on anticoagulant therapy indicates that a care plan must be developed related to the potential side effects, risks and care requirements for a resident receiving anticoagulant medication.
- Bruising of unknown etiology was observed on three separate occasions to different locations on Resident #1's body. The written plan of care for Resident #1 did not provide any directions to staff on potential complications related to anticoagulant therapy [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to Resident #1 as specified in the plan.

- Resident #1 was admitted to the home with an order for administration of an anticoagulant drug. The admission laboratory orders indicate the requirement for monthly international normalized ratio (INR) monitoring.
- Interviews held with Registered staff and members of the management team confirmed that monthly INR monitoring was not conducted for Resident #1 as specified in the plan of care [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 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 regarding anticoagulant therapy (if applicable), 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 failed to ensure that the homes medication policy on anticoagulant therapy was complied with:

- The licensee's anticoagulant therapy policy indicates that all residents receiving anticoagulant therapy are to have weekly INR testing completed to confirm they are in the therapeutic range for anti coagulation. The Registered staff are to confirm that the physician has also provided an order for weekly blood work if applicable.
- Resident #1 was admitted to the home with an order for the administration of an anticoagulant drug. The admission orders document the requirement for monthly follow up with INR monitoring.
- On a specified date, Resident #1 was transferred to the hospital due to decreased oral intake and level of consciousness. Upon admission at the hospital it was discovered that the resident's INR level was not monitored as per the physicians order and the home policy. The resident was diagnosed with an intracranial bleed and returned to the home on a palliative status. The resident later passed away in the home.
- Interviews held with Registered staff indicate that confirmation with the physician regarding INR monitoring was not conducted by the Registered staff upon admission as per the home's policy [s. 8. (1)]

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 in compliance with and is implemented in accordance with all applicable requirements under the Act, and complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
17. Drugs and treatments. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of drugs and treatment for Resident #1.

- Resident #1 was admitted to the home with an order for an anticoagulant drug that requires monitoring of the resident for potential side effects and risks. Over a specified period, the resident displayed risks associated with anticoagulant medications. Initially the resident was noted with bruising of unknown etiology and subsequently bruising to other locations on his/her body. No assessment was conducted regarding the bruising of unknown etiology.
The resident experienced episodes of emesis over a specified period and was noted to be lethargic during the same time period. On a specified date, Resident #1 was transferred to the hospital due to noted decrease in level of consciousness. Resident #1 was diagnosed with an intra-cranial bleed and was deemed palliative upon return to the home.
- Interview held with a member of the management team confirmed that there was a lack of assessment regarding side effects associated with anticoagulant therapy for Resident #1 [s. 26. (3) 17.]

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 the plan of care is based on, at a minimum, interdisciplinary assessment of drugs and treatment for residents, to be implemented voluntarily.

Issued on this 24th day of September, 2013

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