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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 10, 2016	2016_486653_0010	025432-16	Complaint

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

ROMELA VILLASPIR (653)

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): October 6 and 7, 2016.

This complaint intake was related to an alleged resident to resident physical altercation.

This inspection had an associated Critical Incident System report.

During the course of the inspection, the inspector conducted observations of residents and reviewed residents' health records, staff schedules, the home's investigation notes and relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with resident #002's spouse, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Assistant Director of Care (ADOC), and Director of Care (DOC).

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

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care set out clear directions to staff and others who provided direct care to the resident.

On an identified date, a complaint was received by the Ministry of Health and Long-Term Care regarding an alleged physical altercation between residents #001 and #002 which resulted in an injury.

During the course of the inspection, interviews with Personal Support Workers (PSWs) #100 and #102, Registered Practical Nurse (RPN) #103, and the Assistant Director of Care (ADOC), indicated that the identified incident was not witnessed, and that the alleged physical altercation between residents #001 and #002 could not be validated.

Upon further inspection of progress notes, it was identified that residents #001 and #002 had a history of physical altercations.

Record review of resident #001's annual Resident Assessment Instrument-Minimum Data Set (RAI-MDS) assessment from an identified date, indicated that resident #001 had an identified Cognitive Performance Scale (CPS) score, which indicated he/she had cognitive impairment.

Record review of resident #002's quarterly RAI-MDS assessment from an identified date, indicated that resident #002 had an identified CPS score, which indicated he/she had cognitive impairment.

Record review of progress notes, indicated that residents #001 and #002 were roommates for almost two months.

Record review of progress notes indicated the following incidents:
-On an identified date, resident #002's spouse reported to registered staff that resident #001 punched resident #002 on an identified area of the body. Slight redness was noted on the identified area.
-On an identified date, resident #002's spouse found resident #002 sitting on resident #001's bed. Resident #001 claimed that he/she had hit resident #002 as he/she wandered into his/her space. No injury was noted.

Interview with resident #002's spouse stated that the incidents occurred in resident #001

and #002's shared bedroom.

Record review of an identified assessment indicated that resident #001 had an identified behavioural trigger.

Record review of resident #001's written plan of care completed on three identified dates, indicated that staff were to redirect resident #001 from situations in which his/her behaviour was triggered. The written plan of care failed to include what the behavioural trigger(s) were, which provoked the resident to react.

Interviews with PSW #102 and Registered Nurse (RN) #105 confirmed that the identified behavioural trigger was not identified in resident #001's written plan of care.

During an interview, the Director of Care (DOC) acknowledged that resident #001's written plan of care did not provide clear directions to staff regarding the resident's identified behavioural trigger. He/She further indicated that the home's expectation was for the identified behavioural trigger to be included in resident #001's written plan of care, as required. [s. 6. (1) (c)]

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 the resident that set outs 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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Record review of the home's policy titled "RC-02-01-02 Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" last updated April 2016, indicated under reporting procedures, item #1:

"Any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/ designate/ reporting manager or if unavailable, to the most senior Supervisor on shift at that time".

Record review of resident #002's progress notes indicated that on an identified date, resident #002's spouse reported to RPN #108 that resident #001 punched resident #002 on an identified part of the body. RPN #108 checked resident #002 and noted a slight redness on the identified body part.

Interview with resident #002's spouse confirmed that he/she had reported the incident to the identified registered staff at that time.

Interview with RPN #108 stated that he/she did not report the allegation of physical abuse to his/her supervisor, as required.

Interview with the ADOC stated that the incident mentioned above was not reported to the management team at the time it had occurred. He/She further indicated that the home's expectation was for the registered staff to report allegations of abuse to the supervisor and then to the management team as required. [s. 20. (1)]

Issued on this 21st day of November, 2016

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

Original report signed by the inspector.