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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 20, 2017	2017_462600_0019	025459-17	Resident Quality Inspection

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

GORDANA KRSTEVSKA (600), IVY LAM (646), SARAN DANIEL-DODD (116)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): November 9, 10, 14, 15, 16, 17, 20, 21, and 22, 2017.

During the course of the inspection, the inspectors conducted a tour of the home, made observations of: medication administration, staff and resident interactions, provision of care, conducted reviews of health records, and critical incident log, staff training records, meeting minutes of Residents' and Family Council meetings, relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Resident Assessment Instrument RAI) Coordinator, Foot care - private practitioner, Housekeeping Aides, Residents' CouncilPresident, Family Council President, Environmental Service Manager (ESM), and residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Infection Prevention and Control
Medication
Minimizing of Restraining
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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).

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 has failed to ensure that the written plan of care sets out clear directions to staff and others who provide direct care to the resident.

Observation of resident #003 in stage one of the Resident Quality Inspection (RQI) revealed that an assisting device had been in use.

Review of resident assessment record and most recent Minimum Data Set (MDS) assessment on an identified date revealed that resident #003 needed assistance by staff for a specific activity of daily living (ADL) and he/she was using the identified assisting device for that ADL.

Interview with Personal Support Worker (PSW) #109 indicated that he/she was not aware why the assisting device was in use. Further he/she stated there was nothing in the written plan of care to indicate that the resident needed the device or if he/she needed assistance by staff. The PSW stated because the resident never used the side where the assisting device was located he/she was never in situation to apply the device. The PSW confirmed that the written plan of care does not give clear direction to the staff as what the resident's needs are related to assisting device use.

An interview with the DOC confirmed that resident #003's plan of care does not set out clear direction to the staff as to what care the staff is to provide to resident #003 regarding use of assisting device. [s. 6. (1) (c)]

2. Observation of resident #005 during stage one of the RQI revealed needs of

assistance for Continence Care.

Interview with PSW #100, RN #102, housekeeper #108, Environmental Manager #114, and the DOC revealed that the resident had a tendency to try to look after him/herself ignoring his/her needs for assistance by staff.

PSW #100 revealed that when he/she goes to check the resident in the morning, the resident's personal equipment he/she had used would need to be checked and he/she would clean it at that time. Interview with PSW #100 and RN #102 revealed that staff check on resident #005 regularly and respond to his/her call as soon as possible. PSW #100 further revealed that the resident was more apt to use the equipment at night, because during the days, the staff are more aware to check on the resident and ensure they provide the assistance he/she needed. PSWs #100 and RN #102 revealed that there were no directions on the written plan of care to inform staff of the resident's tendency to use the equipment, and for staff to check the resident more regularly to ensure his/her equipment was checked and cleaned.

Review of the resident`s recent MDS assessment on an identified date and the resident's current written plan of care revealed that the resident needed extensive assistance by one staff for a specific ADL due to some physical limitations. The care plan further detailed that the resident uses an equipment at night, and staff were to place the equipment within easy reach, for resident to see it. Review of the resident's written plan of care failed to reveal any direction to staff as to when to check the equipment before the resident re-use it.

Interview with the DOC confirmed that there was a lack of clear direction for the above mentioned concerns, and that it was the home's expectation that residents' written plan of care give clear directions to the staff regarding resident's needs and care to be provided. [s. 6. (1) (c)]

3. During stage one of the RQI resident #002 triggered for worsening pressure ulcer to be further inspected.

Review of the the resident's admission assessment on an identified date indicated that resident #002 was admitted to the home on the identified date, with a skin impairment to the identified body part.

A review of the progress notes and weekly skin assessments over identified period 2017,

documented that the resident received treatment to aid in the healing process. Review of the weekly skin assessment with an identified date of completion indicated the skin impairment had healed.

Interviews held with PSW staff member #103 and registered staff member #107 indicated being aware that the resident was prone to skin impairment and required interventions for prevention of skin impairment.

Review of the initial written plan of care created on specific date, and the most recent written plan of care created on an identified date did not indicate that the resident had compromised skin integrity issues.

Further interviews held with registered staff member # 107 and the DOC confirmed that the written plan of care does not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

4. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The written plan of care created on an identified date, for resident #007 indicated that the resident had a skin condition that affected his/her body parts. The written plan of care directed staff to administer treatment that had been ordered by the physician to relieve symptoms and to apply prescription as ordered.

The physician's order from an identified date directed staff to apply a specific treatment and the physician's order from another identified date directed staff to apply a second treatment on a daily basis to affected areas.

During an interview and review of the treatment cart with registered staff member #113 in November, 2017, it was discovered that the treatments were not available. Registered staff member#113 indicated that he/she was aware that the resident required the treatments on a daily basis and that the last date the creams were available and applied to the affected areas was on an identified date.

Interviews held with registered staff member, the E.D. and the DOC acknowledged that the care set out in the plan of care in relation to prescribed treatments was not provided to resident #007 as specified in the plan. [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 the plan of care set out clear directions to staff and others who provide direct care to the resident
- to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where assisting device are used, the resident had been assessed in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Observation of resident #007 in stage one of the RQI inspection revealed assisting devices were used, while the resident was lying in bed. A staff interview and census record in stage one of the inspection indicated the staff used the device to assist the resident for some ADLs

A review of resident #007's assessments record failed to reveal that the resident was assessed for using assisting devices.

An interview with RPN #113 confirmed that the resident had not been assessed for using assisting devices until the morning of the interview.

Interview with DOC confirmed that the system had been evaluated annually and staff are expected to assess the resident for using an assisting device on admission, when residents' condition change and prior the devices are applied. [s. 15. (1) (a)]

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 where bed rails are used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

The written plan of care for resident #007 indicated that the resident had a skin condition that affected some body parts. The written plan of care directed staff to provide treatment that had been ordered by the physician to relieve symptoms and to apply prescription as ordered.

The physician’s order from an identified date directed staff to apply a specific treatment and the physician's order from another identified date directed staff to apply a second treatment on a daily basis to affected areas.

During an interview and review of the treatment cart with registered staff member #113 in November, 2017, it was discovered that the treatments were not available. Registered staff member #113 indicated being aware that the resident required the treatment on a daily basis and indicated that they were reordered on an identified date. As per registered staff member, the last date the treatments were available was on a specific date.

Review of the medication administration record (MAR) and the treatment administration record (TAR) indicated that the treatments were signed as administered on few dates in November, 2017. Registered staff member acknowledged signing the MAR/TAR although the treatments were not administered.

Further interviews held with the E.D.and the DOC confirmed that the treatments for resident # 007 were not administered in accordance with the directions for use specified by the prescriber on the identified dates for resident # 007. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 20th day of December, 2017

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

Original report signed by the inspector.