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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 11, 2018	2018_684604_0019	013897-18	Follow up

Licensee/Titulaire de permis

Southlake Residential Care Village
596 Davis Drive NEWMARKET ON L3Y 2P9

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

Southlake Residential Care Village
640 Grace Street NEWMARKET ON L3Y 2P6

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

SHIHANA RUMZI (604), AMANDEEP BHELA (746)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): November 27, and 28, 2018.

Compliance Order (CO) #001, issued to the licensee on May 23, 2018, within inspection report #2018_378116_0006, under LTCHA, 2007. c. 8. s. 3 (1) Residents' Bill of Rights was inspected.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Registered Practical Nurse (RPN), Personal Support Workers (PSW), Dietary Manager (DM), and Dietary Aide (DA).

During the course of the inspection the inspectors conducted observations of staff and resident interactions, meal observations, provision of care, conducted reviews of health records, staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Nutrition and Hydration

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)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2018_378116_0006	604

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	Légende 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. (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 :

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

On May 23, 2018, the home was served a Compliance Order (CO) #001, under the Long Term Care Home's Act (LTCHA), 2007, c. 8 s. 3 (1) 4, specifically related to resident #001. The licensee was ordered to develop and submit a plan that included the following requirements and the person(s) responsible for completing the tasks:
1. Provide education and/or re-education on the Residents' Bill of Rights to all direct care and registered staff members of the home.
2. The training should provide a focus on the following Resident Bill of Rights: 4) Every resident has the right to be properly cared for in a manner consistent with their needs.
3. Senior management must communicate the importance of ensuring identified care was provided to residents in a manner consistent with their needs to all individuals involved in the resident's care.
The licensee was successful in complying with order one to three. During the inspection it was identified that resident #001 no longer resided in the home and resident #001 was replaced with resident #002.

The resident sample was expanded to resident #004 and #005, as areas of non-compliance was identified during the initial identified observation which was conducted on an identified date and location of the home.

A record review of resident #004's written plan of care was carried out with an identified last care plan review completed date. The written plan of care consisted of an identified focus which specified resident #004's care requirements.

An identified meal observation was conducted on an identified date by Inspectors #604 and #746, in an identified location of the home. Resident #004 was observed to have identified devices related to assistance needs which was not consisted with the written plan of care.

The resident was observed to be sitting in an identified position, when care was provided by Personal Support Worker (PSW) #104. At an identified time a glass of liquid was placed at the table and PSW #104 sat down on the right side of resident #004, and sat the resident upright. When the PSW started to assist the resident it was observed that the assistance provided to the resident was not according to the residents written plan of care as indicated above. The Inspector asked the PSW what interventions were in place related to assisting the resident. The PSW was able to inform the Inspector of the care which was to be provide to the resident as identified in the written plan of care and started to follow the written plan of care related to how assistance was to be provided.

An interview was conducted with PSW #104 who stated that they reviewed resident #004's written plan of care which was available on the Point of Care (POC) tables. The PSW and Inspector #604 reviewed the resident's written plan of care as indicated above and the PSW acknowledged that they did not follow the written plan of care when they provided assistance to the resident in an identified location of the home when the Inspector was conducting their observation.

Interviews were conducted with Dietary Aide (DA) #105 and Dietary Manager (DM) related to table settings. The DA and DM indicated that they set up the tables for each meal with identified devices as identified on an identified list located in an identified location of the home. The DA and DM indicated as per the identified list resident #004 was to have identified devices. The DA and DM was informed of the above observations and acknowledged that resident #004 was not provided with the identified devices as per the written plan of care.

An interview was conducted with the Director of Care (DOC) who was informed of the above observations conducted for resident #004, and was provided with a copy of the written plan of care, and a copy of an identified list. The DOC reviewed the documents and acknowledged that resident #004 had not been provided assistance in accordance with the plan of care.

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 care set out in the plan of care was 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. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

The licensee had failed to ensure that staff participated in the implementation of the infection prevention and control program.

An identified meal observation was conducted on an identified date and location of the home for resident #002. During the observation the Inspectors observed DA #101 pickup two dirty plates off an identified table and place it under a clean cart with dessert. DA#101 was then observed to serve resident #003's dessert, with no observations of hand hygiene performed in between the handling of the dirty dishes and the dessert.

An interview was conducted with DA #101, who stated staff are aware and have been educated to wash their hands between the handling of dirty dishes and providing food to the residents. The DA was informed of Inspector #604's observation and the DA acknowledged that they did not follow infection control practices in the home as they did not perform hand hygiene in between handling dirty dishes and then serving the dessert to resident #003.

An interview was conducted with the DM #103, who stated it was the home's expectation that staff wash their hands between handling dirty dishes and then handling food. The DM stated all staff where educated annually and as needed on the home's infection control processes and the home's "Safe Pair of Hands" program. The DM stated DA #101 informed them of the observation conducted above by Inspector #604 and #746, and the DM acknowledged that DA #101 did not follow the homes infection control program.

Issued on this 11th day of December, 2018

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

Original report signed by the inspector.