**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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**Public Copy/Copie du public**

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l’inspection | Log # / No de registre | Type of Inspection / Genre d’inspection |
|---|---|---|---|
| Jun 21, 2019 | 2019_516734_0004 | 000269-17, 001023-17, 001560-17, 003469-17, 006638-17, 015706-17, 027206-17, 002549-18, 008696-18, 009258-18, 030250-18, 033572-18, 001574-19, 005630-19 | Critical Incident System |

## 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

JADY NUGENT (734), AMANDEEP BHELA (746), JOVAIRIA AWAN (648), SHIHANA RUMZI (604)

## 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): May 16-17, 21-24, 27-31 and June 3-5, 2019**

**The following critical incidents were inspected upon:**

**Nine related to falls that resulted in injury.**

**Two related to abuse and/or responsive behaviours.**

**One related to personal support services resulting in injury.**

**One related to a medication error resulting in injury.**

**This inspection was completed concurrently with complaint inspection #2019_685648_009 and follow-up inspection #2019_594746_0010.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Acting Directors of Care (ADOC), Nurse Practitioner (NP), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Hairdresser, Facility Staff, Receptionist, family members and residents.**

**The inspectors also made observations of residents and their home areas; and reviewed relevant administrative health records for specified residents.**

**The following Inspection Protocols were used during this inspection:**
**Critical Incident Response**
**Falls Prevention**
**Medication**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Responsive Behaviours**

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

**3 WN(s)**
**1 VPC(s)**
**0 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that no drug was used by or administered to the resident in the home unless the drug had been prescribed to the resident.

The home submitted a Critical Incident System (CIS), on an identified date, to the Ministry of Health and Long Term Care (MOHLTC) Director, indicating a medication incident had occurred which altered a resident's health status. The CIS stated that on an identified date, resident #014's family informed the RPN #124 that the resident had a change in condition, and asked the RPN to assess the resident. The RPN indicated to the family that the resident would be monitored and family would be updated. After a period of time the RPN reassessed the resident and transferred them to hospital for further assessment due to a change in condition. The home was later informed that resident #014 was treated.

A review of resident #014's Electronic Medication Administration Record (EMAR) was carried out on an identified date, and no order for the specified medication related to an incident was noted.

Inspector #604 attempted to contact RPN #144 who was involved in the medication incident with no success. The home indicated the RPN had resigned.

Interviews were conducted with RPN #124 and RN #123, who indicated they worked on the identified date and shift(s). RPN #124 stated the family of resident #014 informed them the resident had a change in condition. Registered Nurse #123 indicated the resident was sent to hospital for further assessment, was found to have been provided with an incorrect medication.

An interview was conducted with the DOC #103 who reviewed the home's CIS and indicated the home conducted an investigation. The DOC stated through the interview process with RPN #144, it was identified that the RPN provided the incorrect medication to resident #014 instead of resident #042. The DOC acknowledged that the incorrect medication was administered to resident #014 which was not prescribed to the resident and the resident was treated in the hospital.

A review of resident #042's EMAR was carried out on an identified date(s), and it was observed that the resident had an order for the medication, and provided instructions on how the medication was to be provided; there was a signature to indicate that the medication where administered. [s. 131. (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 no drug is used by, or administered to a resident in the home, unless the drug has been prescribed to that resident, to be implemented voluntarily.***

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**WN #2: 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 there was a written plan of care for each resident that sets out clear directions to staff and others who provided direct care to the resident.

A CIS was submitted to the MOHLTC Director on an identified date, related to an injury sustained by resident #035.

A review of resident #035’s records indicated at the time of the incident a document was provided to staff, stating that resident #035 was to be a one person transfer. However, the intervention in the plan of care at the time of the incident indicated a two person mechanical lift..

During an interview with PSW #136 they explained that at the time of the incident they had provided care to resident #035. During the interview they indicated they transferred the resident by themselves using a pivot transfer. However, they stated they were unaware of the resident requiring a two person mechanical lift transfer.

During an interview with RPN #137 they provided information that corroborated the information shared by PSW #136, with the use of a one person transfer pivot at the time of the incident. Registered Nurse #138 (RN) stated in the interview, that during the investigation it was discovered that the said document that was used by PSW #136 as a guide did not provide the same direction as indicated in the written plan of care. The home since this incident has removed the said document from all floors, and staff are now required to only use the Kardex.

The home's Assistant Director of Care (ADOC) #139 confirmed that clear directions were not provided to PSW #136, and the staff member would not have been aware that the resident was a two person mechanical. [s. 6. (1) (c)]

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**
**1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).**
**2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,**
**i. a breakdown or failure of the security system,**
**ii. a breakdown of major equipment or a system in the home,**
**iii. a loss of essential services, or**
**iv. flooding.**
**O. Reg. 79/10, s. 107 (3).**
**3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).**
**4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).**
**5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. Subject to subsection (3.1), an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

A CIS report was submitted on an identified date to the MOHLTC Director. The CIS report indicated on an identified date resident #032 sustained a fall, whereby resident #032 sustained an injury and was sent to the hospital.

Based upon progress notes reviewed by Inspector #734, resident #032's aforementioned incident occurred six days prior to it being submitted. Resident #032 was found post fall, and they had sustained injuries as a result. Upon return from hospital on an identified date, resident #032 returned with a change in their health status.The CIS was not submitted to the MOHLTC until six days after the incident. Based on these timelines the home did not follow legislative reporting requirements.

During an interview with ADOC #139 they stated that their submission was late due to improper internal reporting by staff to upper management. Furthermore, ADOC #139 stated that they were unaware of the incident, and once they became aware the reported it to the MOHLTC.

During an interview with Director of Care #103, they stated that they were unaware of resident #032's injury and transfer to hospital that occurred on an identified date. The DOC confirmed that based on legislated reporting requirements that the CIS was submitted late. [s. 107. (3)]

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**Issued on this 15th day of July, 2019**

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

**Original report signed by the inspector.**