Ontario

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
Jun 26, 2019	2019_516734_0003	007316-19	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)

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 2-3, 2019

The following critical incident was inspected upon:

CIS related to a fall that resulted in injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Directors of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and resident.

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:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 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	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 :

1. 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 Critical Incident System (CIS) was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, related to an injury involving resident #001. The resident had a sustained a fall and injury on an identified date while being transferred by a staff member in their mobility device. The CIS indicated the resident was to have a specified intervention in use when using their mobility device while being transferred by staff. At the time of the incident the specified intervention was not in use.

Inspector #734 reviewed resident #001's written plan of care in place at the time of the incident. The written plan of care indicated under the care plan a specified intervention to be in place when the resident was using their mobility device. Records indicated that this intervention was implemented by Registered Practical Nurse (RPN) #100 prior to this incident.

In an interview by Inspector #734 with Personal Support Worker (PSW) #102, they indicated that resident #001 was not one of their primary care assignments on that unit. However, due to circumstances on that day PSW #102 stated that they did transfer resident #001 on that day using their mobility device; while being transferred the resident fell forward and sustained their injuries. PSW #102 indicated that the required intervention was not in use at the time of the fall.

In an interview with RPN #100, by Inspector #734, it was discovered that this was the second incident of this kind involving resident #001. At the time of the first fall a staff member was also transporting the resident when they fell out of their mobility device. RPN #100 stated that resident #001 was not injured. RPN #100 indicated that the resident was assessed by the physiotherapist who recommended the plan of care be updated to require the application of a specified intervention to be used at all times when transferring the resident in their mobility device.

In an interview with PSW #101 by Inspector #734, it was explained that they were the resident's primary care giver that day. PSW #101 indicated that resident #001 required the specified intervention to be on in use on their mobility device while being transferred by staff.

Further to this, in an interview with Inspector #734, Assistant Director of Care (ADOC) #104 and ADOC #105 confirmed that PSW #102 was not following the resident's plan of care at the time of the fall. They indicated that the mobility device used for transferring with resident #001 was to have the specified intervention in use at all times.

Inspector #734 reviewed the internal investigation notes from the incident. The documents confirm that resident #001 at the time of the incident was not being ambulated by Personal Support Worker (PSW) #102 in accordance to the plan of care. Each staff member's statement, along with the interview of resident #001, all corroborated the information within the investigation notes.

The licensee has failed to follow the plan of care set out for resident #001. [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 that ensures the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

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.