Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jan 6, 2022	2021_598570_0024	018085-21, 018545-21, 018895-21, 019138-21	Critical Incident System

Licensee/Titulaire de permis

Southlake Residential Care Village
690 Grace Street Newmarket ON L3Y 8V7

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

Southlake Residential Care Village
640 Grace Street Newmarket ON L3Y 8V7

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

SAMI JAROUR (570), ANGIEM KING (644)

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): December 13-17 and December 20, 2021

The following intakes were completed in this Critical Incident System (CIS) inspection:
- Log #018085-21, CIS report, related to an injury with unknown cause.
- Log #018545-21, CIS report, related to a fall incident.
- Log #018895-21, CIS report, related to a fall incident.
- Log #019138-21, CIS report, related to a fall incident.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Environmental Services Manager (ESM), IPAC lead, Assistant Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurses (RPN), Housekeeper, Personal Support Workers (PSW) and residents.

During the course of this inspection the inspectors conducted observations on resident home areas, reviewed records, observed infection prevention and control practices.

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

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	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 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 :

1. The licensee has failed to ensure that all staff participated in the implementation of the IPAC program.

Inspectors #570 and #644 observed PSW #104 delivering a tray meal service to resident #003. The resident was in isolation and signage posted indicating droplet/contact precautions. The PSW placed the tray on PPE caddy and put on gown without performing hand hygiene and entered resident's room without changing mask and without wearing face/eye shield. When leaving the room, the PSW did not change the mask.

In an interview with PSW #104, they confirmed they did not perform hand hygiene before putting gown on, did not have face shield and did not replace the mask.

In an interview with the DOC, they indicated that the PSW staff did not follow the IPAC practices at the home in regards to performing hand hygiene and using appropriate PPE.

By not adhering to the home's IPAC program, there was minimal risk of harm to residents and staff for the transmission of infectious agents.

Sources: Inspectors' observation; Interviews with PSW #104 and the DOC, Droplet/Contact precautions signage and PPE donning/doffing signage. [s. 229. (4)]

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 all staff participate in the implementation of the IPAC program, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a Personal Assistance Services Device (PASD) was used to assist resident #003 with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

Resident #003 was observed in a tilted position in their wheelchair.

A review of the resident's plan of care identified that the resident uses a wheelchair for mobility. The plan of care did not identify the use of a tilt wheelchair.

In an interview with the physiotherapist, they indicated the resident was using a tilt wheelchair as a PASD for sitting tolerance and for safety.

In an interview with RPN #109, they confirmed upon observation of the resident that the resident was tilted and that they should not have been tilted as the use of tilt wheelchair was not included in the resident’s plan of care.

Sources: Resident #003's clinical records; observations; interview with the physiotherapist and RPN #109. [s. 33. (3)]

2. The licensee has failed to ensure that a Personal Assistance Services Device (PASD) was used to assist resident #002 with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

Resident #002 was observed in a tilted position in their wheelchair.

A review of resident #002's plan of care identified that the resident uses a wheelchair for mobility. The plan of care did not identify the use of a tilt wheelchair.

In an interview with the physiotherapist, they indicated they authorized the use of the tilt wheelchair for the resident as a PASD for sitting tolerance and pressure relief.

In an interview with RPN #126, they indicated resident #002 was using a tilt wheelchair as a PASD for comfort and positioning. RPN #126 confirmed that the use of tilt wheelchair was not included in the resident’s plan of care.

Sources: Resident #002's clinical records; observations; interview with the physiotherapist and RPN #126. [s. 33. (3)]

Issued on this 16th day of January, 2022

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

Original report signed by the inspector.