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
Feb 28, 2022	2022_949529_0006	017782-21, 019421-21, 001465-22	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

ERIC TANG (529), NICOLE LEMIEUX (721709), SUSAN SEMEREDY (501)

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): February 7-11, 14-18, 2022.

During this inspection, the following Critical Incident Reports were inspected:
- a log related to responsive behaviours and prevention of abuse and neglect
- a related to skin and wound
- a log related to the prevention and management of falls

During the course of the inspection, the inspector(s) spoke with the Interim Administrator, the Interim Director of Care (DOC), Assistant Directors of Care (ADOCs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Resident Assessment Instrument (RAI) Coordinator, Personal Support Workers (PSWs), and residents.

During the course of the inspection, the inspector(s) observed resident-to-staff interactions, and reviewed clinical health records, relevant home policies and procedures, internal investigation notes, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
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	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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was reassessed, and the plan of care was reviewed and revised at least every six months, specifically when care set out in the plan was no longer necessary.

A resident had an unwitnessed fall with injury. Documentation indicated that the resident was using equipment to prevent falls prior to the fall. Interviews with staff substantiated that the resident was using a device for falls prevention. Upon review, it was determined that the resident did not have a falls focus or interventions in their care plan and a falls risk assessment had not been completed since admission. Interviews with Resident Assessment Instrument Coordinator (RAI-Coordinator) and Assistant Director of Care (ADOC) indicated that the resident was not at risk to fall, all interventions should have been removed and resolved from the care plan and Minimum Data Set Resident Assessment Protocols and a falls risk assessment should be completed quarterly. The ADOC also indicated that a falls risk assessment had not been completed for the resident since admission. As a result, the resident was not re-assessed for falls risk and there was miscommunication amongst staff about the care needs for the resident related to falls.

The RAI Coordinator and ADOC acknowledged that the resident had not been reassessed quarterly for falls risk since admission.

Sources: CIS report, a resident's health records and assessments including electronic and physical chart, Falls Prevention and Management Program policy December 2020, interviews with ADOC and other staff members. [s. 6. (10) (b)]

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 resident is reassessed and the plan of care reviewed and revised at least every six months and any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #013 was protected from physical abuse by resident #012.

Section 2 (1) of the Ontario Regulation 79/10 defines physical abuse as “the use of physical force by a resident that causes physical injury to another resident.”

Resident #012 had a medical condition and a history of responsive behaviours. Treatments had been adjusted since admission and they were noted to be stable. Resident #012 and resident #013 resided on different floors. Resident #013 was also noted to have responsive behaviours. A visit took place between them and during a visit resident #012 had exhibited responsive behavior that resulted resident #013 injured. Staff members tried to intervene but were unsuccessful.

Treatments were adjusted for resident #012 and an intervention was implemented for future visits. An interview with the director of care confirmed this was physical abuse which resulted in an injury.

Sources: CIS report, review of resident #012 and #13’s clinical record including care plans and progress notes and an interview with the director of care and other staff members. [s. 19. (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 residents are protected from abuse, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
7. Skin condition, including interventions. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the 24-hour admission care plan included interventions for the resident’s skin condition.

The resident was admitted to the home with impaired skin integrity. The admission care plan did not take into consideration the recommended interventions developed prior to their admission until several days after. The resident’s condition deteriorated and required further medical interventions.

An interview with an assistant director of care confirmed the resident's 24-hour admission care plan did not contain the recommended treatments for the resident’s skin conditions.

As a result of failing to include skin condition and interventions into the 24-hour admission care plan, the resident’s skin conditions deteriorated and resulted in a change in their condition.

Sources: CIS report, a resident’s electronic health records including the initial 24-hour care plan, investigation notes, and an interview with an assistant director of care and other staff members. [s. 24. (2) 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 24-hour admission care plan includes resident's skin condition, including interventions, to be implemented voluntarily.

Issued on this 28th day of February, 2022

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

Original report signed by the inspector.