Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 25, 2014	2014_357101_0004	T-221-14	Complaint

Licensee/Titulaire de permis

SOUTHLAKE RESIDENTIAL CARE VILLAGE
640 GRACE STREET, NEWMARKET, ON, L3Y-2L1

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

SOUTHLAKE RESIDENTIAL CARE VILLAGE
640 GRACE STREET, NEWMARKET, ON, L3Y-2L1

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

AMANDA WILLIAMS (101)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 20, 2014

During the course of the inspection, the inspector(s) spoke with the Executive Director, Environmental Manager, registered nursing staff and personal support workers.

During the course of the inspection, the inspector(s) reviewed the home's emergency contingency plans, policies and procedures, written documentation of tested emergency plans; conducted a visual inspection of emergency outlets within the resident home areas.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 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 home did not inform the Director no later than one business day following the loss of an essential service for a period greater than six hours.

Interview with the home's Executive Director and Environmental Manager confirmed that the home was on generator power as a result of a power outage in November 2013. The home had lost power at ~9pm and it was not restored until ~6am (a period of ~nine hours). [s. 107. (3)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (7) The licensee shall,
(a) test the emergency plans related to the loss of essential services, fires, situations involving a missing resident, medical emergencies and violent outbursts on an annual basis, including the arrangements with the community agencies, partner facilities and resources that will be involved in responding to an emergency; O. Reg. 79/10, s. 230 (7).
(b) test all other emergency plans at least once every three years, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency; O. Reg. 79/10, s. 230 (7).
(c) conduct a planned evacuation at least once every three years; and O. Reg. 79/10, s. 230 (7).
(d) keep a written record of the testing of the emergency plans and planned evacuation and of the changes made to improve the plans. O. Reg. 79/10, s. 230 (7).

Findings/Faits saillants :

1. Interview with the Executive Director and Environmental Manager and review of completed written records of tested emergency plans confirmed that the home has not completed tests of emergency plans related to loss of essential services, fires, situations involving a missing resident, medical emergencies and violent outbursts on an annual basis with the exception of fire since June 1, 2010. [s. 230. (7)]

2. Personal support workers interviewed on 2nd, 3rd and 4th floor on days and evening shifts were unaware of actions to take in cases of a power loss in the home. [s. 230. (7)]

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Issued on this 26th day of March, 2014

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