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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## Public Copy/Copie du rapport public

| 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_875501_0002 | 014380-21, 014570-21, 015061-21, 015482-21, 019056-21, 020186-21, 020888-21, 000351-22, 000639-22 | Complaint |

### 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

SUSAN SEMEREDY (501), ERIC TANG (529), JACK SHI (760), NICOLE LEMIEUX (721709)

## 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): February 7-11 and 14-18, 2022.**

**During the course of this inspection the following complaint intakes were inspected:**
**Log #000639-22 related to infection prevention and control (IPAC), nutrition and hydration and staffing;**
**Log #000351-22 related to IPAC, nutrition and hydration and staffing;**
**Log #020186-21 related to dignity, choice and privacy, personal support services and wound care;**
**Log #019056-21 related to medication and admission plan of care;**
**Log #015061-21 related to pain management, wound care, personal support services and IPAC; and**
**Log #014570-21 related to the prevention of abuse and neglect and IPAC.**

**During the course of the inspection, the inspector(s) spoke with the Interim Administrator, Interim Director of Care (DOC), Assistant Directors of Care (ADOCs), Physician, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Social Worker, Resident Assessment Instrument (RAI) Coordinator, Physiotherapist, Nurse Practitioner, Dietary Supervisor, Dietary Aides, Personal Support Workers (PSWs), Resident Assistants (RAs), Housekeepers, substitute decision-makers (SDMs), family members and residents.**

**During the course of the inspection, the inspectors observed resident and staff interactions, dining and IPAC practices. The inspectors reviewed clinical health records, the home’s investigation notes, relevant home policies and procedures and other pertinent documents.**

**The following Inspection Protocols were used during this inspection:**

**Dignity, Choice and Privacy**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Nutrition and Hydration**
**Pain**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Skin and Wound Care**
**Sufficient Staffing**

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

- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**
**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| O.Reg 79/10 s. 26. (3) | CO #001 | 2021_875501_0020 | 501 |

| 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 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).**

**s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).**

**s. 6. (9) The licensee shall ensure that the following are documented:**
**1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).**

**Findings/Faits saillants :**

1.The licensee failed to ensure a resident's plan of care was followed when they had a change in health status.

A review of the resident's progress notes indicated that upon admission, the resident's SDM had expressed their wishes for care. Shortly after admission, a registered staff member found the resident to have a change in health status.

The registered staff member stated that they found the resident to have a change in health status but admitted they did not review the resident's plan of care to see what their wishes were. The Interim Administrator stated that the registered staff member should have checked the resident's plan of care when they noticed the resident had changed and applied the appropriate interventions based on their plan of care.

Sources: Review of resident #004's plan of care, progress notes; Home's policy and education related to code blue emergencies; Interviews with the Interim Administrator and other staff. [s. 6. (7)]

2. The licensee has failed to ensure that staff and others who provided care to a resident were kept aware of the dietary interventions in the resident's plan of care and had immediate access to it.

The Registered Dietitian initiated special dietary changes and instructions for a resident.

A review of the resident's care plan indicated that these special dietary changes were not included. An observation in the dining room indicated the seating plan was not updated with these changes and the dietary profile for the resident was not available in the diet list binder located in the servery. An interview with a staff member indicated that they were not aware of any changes until the day prior when the inspector had been inquiring. An interview with another staff member indicated that the changes were only communicated verbally by the registered staff. An interview with the Dietary Supervisor indicated that these changes were updated on the dietary profile but confirmed that the profile had not been made available to the staff in the servery. The Dietary Supervisor also confirmed that the resident's care plan was not updated.

As a result of not keeping the staff aware of the updated plan of care put the resident at risk for not receiving the specified dietary interventions. [s. 6. (8)]

3. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented for resident #001, #003 and #006.

The written plan of care for each of the above residents indicated they required assistance with all activities of daily living (ADL). Review of the home's documentation reports indicated that no care was documented as provided for five days during a nine-day period for resident #001. The same report for resident #003 and #006 indicated that no care was documented for all days during the same nine-day period. Interviews with staff members indicated that care had been provided but was not documented due to short staffing. An interview with an ADOC confirmed that all care provided is to be documented without exception.

Sources: Clinical records including care plans and documentation reports for resident #001, #003 and #006 and an interview with ADOC #103 and other staff members. [s. 6. (9) 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 the care set out in the plan of care is provided to the resident as specified in the plan, that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it and the the provision of the care set out in the plan of care is documented, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

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

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that their Medication Management policy included in the required medication program was complied with, for a resident

Ontario Regulation 79/10, s.114 (3) (a), indicates that written policies and protocols are to be developed and implemented for the medication management system to ensure the accurate administration of all drugs that are used in the home.

Specifically, staff did not comply with the home’s policy and procedure titled, "Medication Reconciliation", dated December 2020. The policy states that an accurate Best Possible Medication History (BPMH) will be completed for residents who are new admissions into the facility and there would be reliable sources used to ensure an accurate transcription of the resident’s medication orders.

A review of a resident’s medication list from the application package submitted by the Local Health Integration Network (LHIN) compared with the BPMH completed by a registered staff member demonstrated medication discrepancies. The BPMH had missing medications that were listed on the admission package from the LHIN. The RAI Coordinator confirmed that there were medications that were not transcribed onto the BPMH from the admission package from the LHIN. The Interim Administrator confirmed that the registered staff member did not follow the home’s medication reconciliation policy. Failure to accurately transcribe a resident’s medication list may result in missed medical care for the resident.

Sources: Home’s policy titled, “Medication Reconciliation”, dated December 2020; Review of a resident’s admission package from the LHIN; Review of the resident’s BPMH from their date of admission; Interviews with the RAI Coordinator, Interim Administrator and other staff. [s. 8. (1) (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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

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

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to fully respect and promote a resident's right to receive visitors of their choice.

A friend of a resident came to the home to visit with the resident and was told they were not allowed into the building and were to contact the resident's substitute decision-maker (SDM).

An interview with the resident indicated they could communicate and interviews with staff members acknowledged the resident was able to make their wishes known. An interview with the Social Worker confirmed the resident had never been asked whether they wanted to have a visit with the friend. An interview with the Administrator indicated the home had not fully promoted the resident's right to receive visitors as the home had not asked the resident.

Failing to fully promote the resident's right to see visitors puts them at risk of isolation.

Sources: Review of a court order, email communication between family member and the home, the resident's clinical record including progress notes and interviews with Social Worker and other staff members. [s. 3. (1) 14.]

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**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.**