



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 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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Table with 4 columns: Report Date(s) / Date(s) du Rapport, Inspection No / No de l'inspection, Log # / Registre no, Type of Inspection / Genre d'inspection. Row 1: Sep 5, 2013, 2013_102116_0040, T-278-13, 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

SARAN DANIEL-DODD (116)

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): August 19, 20, 22, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, Registered staff, personal support workers and residents.

During the course of the inspection, the inspector(s) reviewed the health record of residents, observed staff to resident interactions and the homes responsive behaviour policy (#09-05-01).

The following Inspection Protocols were used during this inspection: Responsive Behaviours



Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care Specifically failed to comply with the following:

- s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
 5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :



1. The licensee failed to ensure that the written plan of care for Resident #1 was based on an interdisciplinary assessment of the resident that includes wandering and identified responsive behaviours.

- Resident # 1 was admitted to the home with identified responsive behaviours due to a medical condition.
- Interviews held with staff members confirmed the resident wanders and displays verbal, physical and sexual aggression towards identified residents and staff members of the home [s. 26. (3) 5.].

2. - Resident #2 expressed concerns to the Inspector regarding Resident #1's wandering behaviour. On two occasions, Resident #1 has wandered into Resident #2's room and rummaged through his/her belongings which is upsetting to Resident #1.

- There are no identified triggers or interventions in place to manage sexual aggression and wandering for Resident #1 [s. 26. (3) 5.]

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 written plan of care for Resident #1 is based on an interdisciplinary assessment of the resident that includes wandering and identified responsive behaviours, to be implemented voluntarily.

Issued on this 5th day of September, 2013

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