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 11, 2020	2020_823653_0004	023599-19, 023665-19, 023668-19	Complaint

Licensee/Titulaire de permis

Southlake Residential Care Village
596 Davis Drive NEWMARKET ON L3Y 2P9

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

ROMELA VILLASPIR (653)

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): January 8, 9, 10, 14, 2020.

The following complaint log intakes had been inspected:
-#023599-19 and #023668-19 related to allegation of abuse of resident #001.
-#023665-19 related to whistle-blowing protection and personal support services.

During the course of the inspection, the inspector conducted observations of the resident, reviewed the staff schedule, clinical health records, hospital records, the home's investigation notes, staff training records, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Substitute Decision-Maker (SDM), Sexual Health Worker (SHW), York Regional Police Detective Constable, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Social Worker (SW), Assistant Director of Care (ADOC), Director of Care (DOC), and the Executive Director (ED).

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the written plan of care was provided to resident #001 as specified in the plan.

The Ministry of Long-Term Care (MLTC) received a complaint related to allegation of abuse of resident #001.

The home had notified the MLTC and subsequently submitted a Critical Incident Report (CIR) to report allegation of abuse of resident #001. The home indicated Registered Nurse (RN) #101 had witnessed an interaction between the resident and an individual which the RN perceived as abuse.

A review of resident #001's quarterly assessment indicated they had cognitive impairment and that they required an identified number of staff to assist them for all aspects of care including transfers.

A review of progress notes from an identified time period indicated several documentations that resident #001 was unable to voice their needs due to cognitive impairment and was dependent on staff for all Activities of Daily Living (ADL) needs. Further review of progress notes and separate interviews with Personal Support Workers (PSWs) #104, #111, RN #101, Registered Practical Nurse (RPN) #105, and the Assistant Director of Care (ADOC) indicated when resident #001's Substitute Decision-Maker (SDM) would come and visit the resident, they would provide personal care on their own without the assistance of staff, with the exception of transfers. The ADOC further indicated that the home had numerous conversations with the SDM about the required staff assistance for resident #001's care.

The licensee has failed to ensure that the care set out in the written plan of care was provided to resident #001 as specified in the plan. [s. 6. (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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A review of the home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" #RC-02-01-02 dated June 2019, indicated under reporting that any employee or person who becomes aware of an alleged, suspected, or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/ designate/ reporting manager or if unavailable, to the most senior Supervisor on shift at that time.

The MLTC received a complaint related to allegation of abuse of resident #001.

The home had notified the MLTC and subsequently submitted a CIR to report allegation of abuse of resident #001. The home indicated RN #101 had witnessed an interaction between the resident and an individual which the RN perceived as abuse.

An interview with RN #101 stated on an identified date and time, they had witnessed an interaction between resident #001 and an individual which they perceived as abuse. RN #101 indicated they felt uncomfortable with what they had witnessed and reported the incident to the ADOC three days later. The RN confirmed they did not comply with the home's policy on abuse as they did not immediately report the allegation of abuse to their supervisor as required.

Separate interviews with the ADOC, DOC, and the Executive Director (ED) acknowledged that RN #101 did not immediately report the allegation of abuse to their supervisor as required and that the home's policy on abuse was not complied with by the RN. [s. 20. (1)]

Issued on this 13th day of February, 2020

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

Original report signed by the inspector.