Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: May 16, 2023	
Inspection Number: 2023-1438-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: Southlake Residential Care Village	
Long Term Care Home and City: Southlake Residential Care Village, Newmarket	
Lead Inspector Amanda Belanger (736)	**Inspector Digital Signature**

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 2-5, 2023

The following intake(s) were inspected:

- Four intakes related to allegations of staff to resident abuse;
- One intake related to an improper transfer resulting in a significant change in status for a resident;
- One intake related to an injury of unknown cause;
- Three intakes related to complaints received by the Director related to resident care concerns;
- One intake related to improper care and transfer of a resident; and,
- One intake related to a resident fall that resulted in injury.

The following intakes were completed in this inspection: Three intakes related to an injury with a significant change in condition.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect

Residents' Rights and Choices
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that the resident was protected from abuse by the Personal Support Worker (PSW).

Summary and Rationale
The resident reported that the PSW had displayed actions towards them that were cause of concern.

Internal investigation notes indicated that the allegation of the PSW to the resident abuse was founded.

The Administrator confirmed that the resident had not been protected from abuse by PSW.

There was actual harm to the resident.

Sources: Critical Incident (CI) report; the resident's progress notes; internal investigation notes; and, interviews with the Administrator, and other staff.

[736]

WRITTEN NOTIFICATION: Reporting Allegations of Improper Care to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee has failed to ensure that an allegation of improper care of the resident was immediately reported to the Director.

Summary and Rationale
The resident was transferred improperly, and as a result of the incident, the resident sustained an injury.

The licensee submitted a report to the Director related to improper or incompetent care of the resident, days after the incident took place.

The Administrator acknowledged that improper care of a resident was to be reported immediately, and they indicated that this incident should have been immediately identified to the Director using the after hours pager.

Sources: CI report; and, interview with the Administrator.

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WRITTEN NOTIFICATION: Reporting Allegations of Resident Abuse to the Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that allegations of staff to resident abuse were immediately reported to the Director.

Summary and Rationale
1) Two PSW students felt that they had witnessed a staff member neglect and abuse three separate residents. The students did not bring forward their concerns immediately, and the instructor did not immediately notify the home.

The Administrator confirmed that the students should have immediately brought forward the allegations of staff to resident abuse.

2) The resident indicated that to staff on the home area that they felt they were abused by other staff members.

The licensee did not make the Director aware of the allegation of staff to resident physical abuse until more than 12 hours after the resident first made the concern known.

The Administrator confirmed that the staff should have immediately called the after hours line to report the allegation of staff to resident abuse.

Sources: CI reports; internal investigation notes; and, interviews with Administrator, and other staff.

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WRITTEN NOTIFICATION: Reports to the Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 2. i.

The licensee has failed to ensure that when required to inform the Director of an incident, that the resident's name was included in the report.

Summary and Rationale
A report was submitted to the Director related an incident that resulted in harm to the resident. The report did not contain the resident's name.

The Administrator confirmed that the resident's name was not included in the report and should have been.

Sources: CI report; interviews with Administrator, and other relevant staff.

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COMPLIANCE ORDER CO #001 Safe Lifts and Transfers

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

A) Designate a member of the nursing management team, or the physiotherapy team to provide in person retraining of the Registered Practical Nurse (RPN) and PSW regarding safe lifts and transfers of residents, and reviewing residents plans of care; including physical demonstrations of how to complete safe transfers for the resident.

B) Designate the nursing consultant to provide in person retraining of the nursing management team on safe lifts and transfers, including an overview of when a resident would be considered safe to utilize each of the various transfers;

C) Conduct safety talks on all home areas, and shifts for all PSWs, RPNs, RNs, and agency nursing staff related to safe lifts and transfers, choosing the appropriate lift, and following the resident's plan of care. The home shall keep records of each safety talk, including who provided the information, the date of the safety talk, what information was covered, and who attended the training;

D) Conduct, and maintain randomized audits on all home areas, on all shifts, to ensure that staff are utilizing safe lifts and transfers, including any corrections related to deficiencies for a period of four weeks. Analyze the result of the audits, and provide retraining to correct the deficiencies.

E) Keep documentation of all training, including the date of the training, who provided the training, and what was covered. These documents are to be made available to the Inspector upon request;

Grounds
The licensee has failed to ensure that staff transferred residents, using safe transferring techniques.

Summary and Rationale
1) A resident was noted to be non weight bearing and required the use of a specific lift for transfers.

Internal investigation notes provided by the home indicated that the RPN and another staff member completed a different transfer for the resident.

The Director of Care (DOC) indicated that based on the resident's plan of care, assessment, and investigation notes, the staff members did not complete a safe transfer of the resident.

There was actual risk to the resident as the resident.

Sources: The resident's care plan, progress notes, and physiotherapy assessment; internal investigation notes; interviews with the DOC, and other relevant staff.

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2) A resident was noted to require the use of a specific lift when being transferred.

The CI report indicated that the PSW was transferring the resident, while not using the lift required.

In an interview with the RPN, they indicated that based on the resident's plan of care, and their recollection of the incident, it was not a safe transfer for the resident.

The Administrator indicated that based on the home's internal investigation notes, the CI, and the resident's plan of care, the resident was not transferred in a safe manner.

There was actual harm to the resident.

Sources: The resident's care plan, and progress notes; CI report; interview with the PSW, the Administrator, and other staff.

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3) A resident was transferred via a mechanical lift with only one staff member present, although the home required two staff to be present for all mechanical lifts. As a result of the transfer, the resident sustained an injury.

Progress notes further indicated that on another date, the resident was transferred using a lift that was not indicated in the resident's plan of care.

The Administrator indicated that in both these instances, the resident was not transferred by staff in a safe manner.

There was actual risk of harm to the resident by the resident not being transferred in a safe manner.

Sources: The resident's care plan and progress notes; CI report; safe lift and transfer policy; interviews with the Administrator and other staff.

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This order must be complied with by June 30, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.