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
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Original Public Report

Report Issue Date: December 27, 2023

Inspection Number: 2023-1438-0003

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Southlake Residential Care Village

Long Term Care Home and City: Southlake Residential Care Village, Newmarket

Lead Inspector	**Inspector Digital Signature**
Suzanna McCarthy (000745)	Suzanna McCarthy Digitally signed by Suzanna McCarthy Date: 2023.12.27 14:37:06 -05'00'

Additional Inspector(s)
Deborah Nazareth (741745)
Jovairia Awan (648)
Rodolfo Ramon (704757)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 12, 13, 16-20, 23-25, 30, 31, 2023.
The inspection occurred offsite on the following date(s): October 27, 2023.

The following intakes were inspected:
• Intake: #00088039 - Follow-up #1 – Compliance Order (CO) #001 / 2023-1438-0002, O. Reg. 246/22 s. 40 Transferring, Compliance Due Date (CDD) June 30, 2023.

The following intakes were completed in this complaints inspection:

• One intake related to improper care, neglect, staffing levels, and plan of care.
• One intake related to menu planning and food production.
• One intake related to staff to resident abuse.

The following intakes were completed in this Critical Incident (CI) inspection:
• Five intakes related to alleged staff to resident physical abuse.
• One intake related to alleged improper care.
• One intake related to alleged staff to resident sexual abuse.
• One intake related to missing controlled substance.
• One intake related to alleged resident to resident sexual abuse
• Two intakes related to alleged resident to resident physical abuse.
• One intake related to fall prevention and management.

The following intakes were completed in this inspection: Two intakes related to falls.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1438-0002 related to O. Reg. 246/22, s. 40 inspected by Deborah Nazareth (741745)

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

Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that a resident's written plan of care provided clear directions to staff and others who provide direct care to the resident.

Rationale and Summary
A Critical incident report (CIR) was submitted to the Ministry of Long-Term Care (MLTC) on a specified date, which identified that a resident experienced a fall with injury. The resident's plan of care identified specific actions required during transfers. The Personal Support Worker (PSW) indicated that they provided the resident care without transferring them, while another PSW indicated they transferred resident for care.

Interdisciplinary staff and the Director of Care (DOC) acknowledged that the plan of care lacked clear direction with regards to safe and proper transferring
Failure to follow safe transfer guidelines created a risk of future falls and injury to the resident.

Sources: Interviews with PSW's, Registered Practical Nurse (RPN), Physiotherapist, and the DOC, resident progress notes, assessments, and plan of care records. [648]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

Duty of licensee to comply with plan
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.

The licensee has failed to ensure that care was provided to a resident in accordance with their care plan, specifically two staff for hygiene care.

Rationale and Summary
A Critical Incident was submitted to the Ministry of Long-Term Care (MLTC) after a resident reported to staff that they had been hurt and frightened during the provision of care by an unknown staff member.

During an interview with the resident, the resident reported that during the initial event recorded in the CIR, they were frightened and felt that the single staff providing care had handled them in a rough way. The resident additionally reported that since this time their care has often been provided by single staff due to staff being on break or otherwise unavailable. The RPN indicated that there are occasions when the resident's care will be provided by a single staff member if the unit is short staffed or if staff are on break.
Failure to follow the resident's plan of care which required two staff to provide

extensive assistance for all areas of hygiene placed resident at increased risk of discomfort during care.

Sources: the resident's care plan, CIR, LTCH's investigation notes, interview with the resident, and RPN. [000745]

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that the resident was protected from physical abuse by a PSW.

Section 2 (1) of Ontario Regulation 246/22 defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain".

Rationale and Summary
The Long-Term Care Home (LTCH) reported to the Director an incident of staff to resident physical abuse. During dinner in the dining room, the resident was being assisted with their meal by a PSW. The resident spat out food on the PSW and the PSW responded by striking the resident with their open hand. The resident grimaced after being struck by the PSW. After the incident, the PSW removed the resident's clothing protector, used it to wipe the resident's mouth and removed the resident from the dining room. The abuse was witnessed by another PSW and

reported to the RPN. The PSW continued to provide care to the resident after the incident of witnessed abuse.

The Director of Care (DOC) confirmed that the physical abuse was founded and the resident had not been protected from abuse by the PSW.

There was actual harm to the resident when they were struck in the face by the PSW.

Sources: Resident's clinical record, CIR #2955-000025-23, LTCH's investigation notes, video footage from date of incident, interviews with PSW's, RPN and the DOC. [741745]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, 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.

The licensee failed to ensure that the PSW and RPN complied with the home's policy to promote zero tolerance of abuse and neglect of residents.

Rationale and Summary
The LTCH submitted a CIR regarding an incident of staff to resident physical abuse. The PSW confirmed that they witnessed another PSW strike the resident during a

meal on a specified date. The PSW reported what they saw to the RPN and both staff decided to wait until after the meal to report the incident to a supervisor. The RPN and the DOC confirmed that the PSW continued to provide care to the resident after the witnessed incident of abuse.

The LTCH's policy on responding and reporting resident abuse stated that staff are expected to immediately respond to any form of abuse. Further, staff must immediately report to management or the most senior supervisor on shift at the time.

The PSW and RPN admitted they should have intervened by removing the other PSW from the resident and immediately reported the witnessed abuse to the supervisor.

The resident was at risk for further abuse by the PSW when the staff failed to report the witnessed abuse immediately to their supervisor.

Sources: Resident's clinical record, CIR #2955-000025-23, LTCH's investigation notes, policy Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, RC-02-01-02, Last Reviewed: January 2022, interviews with PSW, RPN and others. [741745]

WRITTEN NOTIFICATION: Orientation

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2)

Training
Orientation
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1)

performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

The licensee failed to ensure that the PSW received orientation training prior to performing their responsibilities in the home.

Rationale and Summary
As defined in FLTCA, 2021, s. 80 (2), "agency staff" means staff who work at the long-term care home pursuant to a contract between the licensee and an employment agency or other third party. In accordance with FLTCA, 2021, s. 80 (3) a staff member who is agency staff, is considered to be hired when they first work at the home.

The LTCH submitted a CIR that alleged a PSW physically abused a resident. Upon review of records, it was noted that the PSW had failed to complete a specified number of mandatory training courses prior to working with residents in the home

areas. Training records showed that the PSW had engaged with the training program for a specified amount of time.

The ADOC and the DOC confirmed that the PSW could not have completed the mandatory training courses within the identified time frame. The PSW admitted that they did not do any training including e-learning prior to starting work in the LTCH in April 2022.

Failing to ensure that the PSW completed their mandatory training posed a risk to the residents' health and well-being.

Sources: PSW's training record and staff record. Interviews with the PSW, ADOC and the DOC. [741745]

WRITTEN NOTIFICATION: Compliance with Manufacturers' instructions

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26

Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The licensee has failed to ensure that staff use supplies in the home in accordance with manufacturers' instructions.

Rationale and Summary
A complaint was submitted to the MLTC alleging the home did not prepare

thickened fluids appropriately. During the inspection, the home was identified to use ThickenUp Clear as a thickening agent for their therapeutic milkshakes for residents requiring thickened fluids. Manufacturers guidelines specified measured recipe for the preparation of thickened fluids, and a 24-hour shelf life of the prepared fluid. Labelled thickened milkshakes for residents in the home were identified to have been prepared over 24 hours in advance of point of service at morning, afternoon, and evening nourishment pass.

Two Dietary Aide's (DA) identified kitchen staff prepared and thickened these milkshakes at 0500 hours (hrs) the prior day. Two PSW's identified they would occasionally add additional thickening agent to their labelled thickened milkshakes on the unit without identifying the use of the manufacturer's recipe.

Observations and reported process were discussed with Dietary Manager (DM) indicating the home's failure to ensure manufacturer's recommended recipe and shelf life were adhered to as beverages were stored past the 24-hour shelf life and PSW staff on the unit were using additional thickener without clear direction.

There was potential risk to residents requiring thickened fluids to manage swallowing difficulty and/or risk of choking through the provision of inadequately prepared thickened fluids.

Sources: Observations, interviews with dietary and PSW staff, and review of thicken up manufacturer's guide. [648]

WRITTEN NOTIFICATION: Food Production

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (2) (f)

Food production
s. 78 (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and

The licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, communication of the seven-day and daily menus to residents.

Rationale & Summary
The home failed to communicate the correct seven-day menu to residents during the course of this inspection. Unit observations identified inconsistent weekly menu options posted throughout the home. Week 1 and Week 2 seven-day menus were posted on different units at the same time.

Observations during the inspection identified the daily Lunch Menu was not posted on several units in the home on two instances.

Failing to provide the planned menu may impact the residents' enjoyment of their meal and overall nutritional intake as they were not provided an opportunity to choose their meals according to the pre-planned and posted menu.

Sources: Observations, and interviews with dietary aide staff and DM. [648]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 1.

Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a

dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.

The licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, communication of the seven-day and daily menus to residents.

Rationale and Summary
During routine observations made during the inspection identified lunch meal substitutions were made for the resident meals. Review of posted lunch menu did not identify the food items served as noted substitutions. Upon inquiry dietary staff were unable to clarify which department was responsible for posting of substitutions to inform residents and staff. The DM confirmed substitutions were not communicated to the residents and staff on the dates observed.

Failure to communicate menu substitutions to residents and staff negatively impacts the quality of meal service.

Sources: Menu posting and lunch service observations on October 12 and 16, 2023, interviews with DA's.
[648]

WRITTEN NOTIFICATION: Security of drug supply

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 1.

Security of drug supply
s. 139 1. All areas where drugs are stored shall be kept locked at all times, when not in use.

The licensee has failed to ensure that all areas where drugs are stored was always kept locked when not in use.

Rationale and Summary
The LTCH submitted a CIR related to a missing controlled substance on home area 4 East. A resident had an order for a medication to be administered as needed. The medication was counted on a specified date and time and the count was correct. At a later date, there were a specified number of capsules unaccounted for.

It was observed that the LTCH stored residents' medication in a medication cart that is to be kept locked when not in use. The Medication cart is stored in the unit's nursing station when not in use. The nursing station is accessible to multiple staff including, nurses, personal support workers, housekeepers, and others.

An RPN working on the fourth floor during the night shift during a specified date range confirmed the medication count was correct on a specified date and that they did not administer the resident's medication during their shift. The RPN admitted that there was a period during their shift where they did not have the unit's medication keys with them after completing the narcotic count. The RPN had left the unit and upon returning they found the nursing station room's door opened and the medication cart was unlocked. The RPN locked the medication cart but did not check the narcotic storage bin in the cart. At the end of the shift, it was discovered that seven capsules of the medication were missing. The LTCH's investigation was unable to determine what happened to the unaccounted for medication.

The RPN and ADOC confirmed the nurse on duty was responsible for the security of the medication supply and to ensure that areas where drugs are stored are kept locked when not in use.

There was no impact to the resident as they received their medication as ordered. There was a risk to the security of the drug supply as the LTCH was unable to determine what happened to the missing controlled substance.

Sources: Resident's clinical record, CIR #2955-000041-22, LTCH's investigation notes, policy Medication Storage Areas, Policy No: 3.4, last revised June 30, 2023, interviews with the RPN, ADOC and others. [741745]

WRITTEN NOTIFICATION: Exceptions

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 254 (4)

Exceptions
s. 254 (4) If a staff member is hired or a volunteer is accepted during a pandemic and no police record check that complies with subsections 252 (2) and (3) was provided to the licensee, the licensee shall ensure that a such police record check is provided to the licensee within three months after the staff member was hired or the volunteer was accepted, and the licensee shall keep the results of the record check in accordance with the requirements in section 278 or 279 as applicable.

The licensee failed to ensure that when a PSW was hired during a pandemic, a police record check was provided to the licensee within three months.

Rationale and Summary
As defined in FLTCA, 2021, s. 80 (2), "agency staff" means staff who work at the long-term care home pursuant to a contract between the licensee and an employment agency or other third party. In accordance with FLTCA, 2021, s. 80 (3) a staff member who is agency staff, is considered to be hired when they first work at

the home.

The LTCH submitted a CIR that alleged the PSW physically abused a resident. The PSW was first hired at the home in April 2022. The PSW was working at the home through a staffing agency and was providing direct care to residents. At the time of hire, the PSW provided an outdated police record. The PSW confirmed that they did not complete a new police record check within three months after they were hired by the LTCH.

The ADOC and the DOC acknowledged that the PSW's police record check was outdated and that a new police record check was not provided to the LTCH within three months of hiring the PSW.

Failing to ensure a police record check was provided to the LTCH for staff providing direct care to residents, places the residents at risk.

Sources: the PSW's police record check and staff record. CIR #2955-000025-23. Interviews with the PSW, ADOC and DOC. [741745]