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

Public Report

Report Issue Date: April 2, 2025
Inspection Number: 2025-1438-0003
Inspection Type: Complaint Critical Incident
Licensee: Southlake Residential Care Village
Long Term Care Home and City: Southlake Residential Care Village, Newmarket

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 19 - 21, 24 - 28, and April 1- 2, 2025.

The following intake(s) were inspected:

- An intake related to a complaint of alleged staff to resident neglect.
- An intake related to staff to resident neglect.

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

Resident Care and Support Services
Prevention of Abuse and Neglect
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Training

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (6) 2.
Training
s. 82 (6) Every licensee of a long-term care home shall ensure that the following are done:
2. The further training needs identified by the assessments are addressed in accordance with the requirements provided for in the regulations.

The licensee failed to ensure further training needs identified for Personal Support Worker (PSW) #102 were addressed in accordance with the requirements provided for in the regulations.

An internal investigation was conducted in the Long Term Care Home (LTCH) following an incident related to resident #001, who was under the care of PSW #102. The outcome of the investigation identified resident #001 was neglected by PSW# 102. A disciplinary sanction was delivered, and further training was required to be completed by a specific date.

Record review and interview with Assistant Director of Care (ADOC) #104 related to PSW #102 training records, demonstrated the staff failed to complete the required training by the designated date, and ADOC acknowledged they were late with their review to ensure the training was completed by the required date.

Sources: Employment records of PSW #102, and interview with ADOC #104.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure staff used safe transferring and positioning devices and techniques when assisting resident #001.

Resident #001's was identified with cognition impairment, and their care plan identified the resident required assistance for identified aspects of care, additionally it directed two staff for transfers, using a specific mobility equipment, as needed by the resident.

The home's Safe Lifting With Care Program, indicated if a resident uses more than one transfer type to document on the care plan, to remain with resident during the entire time when the resident was using the mobility equipment, and to never leave the resident unattended.

PSW #107 indicated they found resident #001 in a specific room, during their shift, attached to a specific mobility equipment. The video footage demonstrated once the resident was taken out of the identified room and taken into their room, staff assisted and transferred the resident to bed using a mobility device not specified in their plan of care. Physiotherapist (PT) indicated they have not received a referral to reassess resident #001.

Sources: Resident #001's health records, internal investigation notes, video footage, Safe Lifting With Care Program, and interviews with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure that resident #001 who experienced altered skin integrity received a weekly skin assessment until their skin condition was resolved.

Resident #001's health records documented they presented with impaired skin condition following an incident. There were no records related to a weekly skin and wound assessment completed for the resident during an identified period. A progress note indicated days after, the resident had no skin impairment in the identified areas.

The Skin and Wound champion Registered Practical Nurse (RPN) #107 acknowledged there was no weekly skin and wound reassessment completed for the resident per the expectations.

Sources: Resident #001's progress notes and skin and wound assessments, and interview with staff.

WRITTEN NOTIFICATION: Complaints reporting certain matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 111 (1)
Complaints — reporting certain matters to Director
s. 111 (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under

section 28 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 108 (1).

The licensee failed to report a complaint regarding resident's #001 neglect to the Director, when a complaint was received by the LTCH regarding the neglect of resident #001.

Resident #001's Substitute Decision Maker (SDM)'s stated their concerns related to the neglect of their loved one through e-mail on an identified date.

ADOC #110 confirmed having received the complaint via email. ADOC #104 indicated records related to the SDM's complaint was not included on the home's Complaint Log binder, and confirmed a CIR was not submitted to the Director related to the received complaint.

Sources: Email communication between resident #001's SDM and the LTCH, LTCH's Complaint Log binder, and interview with staff.

COMPLIANCE ORDER CO #001: Duty to protect

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

(1). Conduct an interdisciplinary meeting to review all aspects of resident #001's

care, including mobility, mechanical transfer needs, and toileting routine. The meeting shall involve the resident's Substitute Decision Maker (SDM), management, attending physician, registered staff, personal support care staff, and physiotherapy. Record detailed documentation of the meeting discussions, date of the meeting, attendees, and changes made to the resident's plan of care. Provide the records upon Inspector's request.

(2). Develop and implement a safety check routine for resident #001, which includes each shift, every day of the week. The safety check routine should outline staff roles and responsibilities, the name of the designated staff to complete the check, the frequency and specific timing of the checks during a given shift, and documentation to ensure checks are completed

(3). The Director of Care (DOC) or management designate, in collaboration with Physiotherapy, will provide in person education to Personal Support Workers (PSWs) #101, #102, and #107, on the home's Safe Lifting With
Care Program, and the Zero Tolerance of Resident Abuse and Neglect Program. The education records will include:

(a). Name of who attended the education.
(b). Date and time on when the education was provided.
(c). Contents of the education.
(d). Name of the person(s) providing the education.
(e). Keep a written records of the education and make available to the Inspector upon request.

(4) The DOC or management designate will conduct audits three times per week, for a period of three weeks on PSWs #101, #102, and #107. The audit will include:

(a). Observation completed when the staff is transferring a resident using any mechanical lift.

(b). Date and time of the audit, the home area and who completed the audit.
(c.) Audits will include direction related to transfers notes in the resident's care plan in comparing to the observed transfer, including documentation of any corrective action.
(d). Keep a written record of the audit and make available to the Inspector upon request.

Grounds

1) The licensee has failed to protect resident #001 from neglect by PSWs #101 and #102.

Ontario Regulation (O. Reg) 246/22, section (s.) 7 defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary
A complaint was submitted to the Director related to staff to resident neglect.

Resident #001's plan of care documented they had cognitive impairment, and identified the resident to have one to two staff assistance for identified aspects of care, and it directed staff to have two-person side by side for transfers, using a specific mobility equipment, as needed by the resident.

Internal investigation records provided by the LTCH confirmed the resident was left unattended, in an specific room by PSWs #101 and #102 during their shift. Video surveillance footage confirmed the resident was found time after by PSW #107 who confirmed the resident was found in a specific position, and attached to a mobility device.

The home's "Safe Lifting With Care Program", under the Safe Resident Handling Procedure for an specific mobility device, directed as a safety point to "never leave the resident unattended".

ADOC #104 confirmed the neglect was substantiated and further disciplinary actions were followed related to PSW #101 and #102.

Sources: Resident #001's health records, LTCH's internal investigation package, video footage, and interview with staff.

2) The licensee has failed to protect resident #001 from neglect by PSWs #101, #102, and #107.

Rationale and Summary
Camera footage from an specific unit, confirmed resident #001 was left in an identified room, unattended for a long period of time by PSWs #101 and #102. It is observed when both staff exited the room shortly after without the resident, and not entering the room for the reminder of their shift.

In an interview with PSW #107 it was confirmed the staff failed to complete the resident census for resident #001 at the beginning of their shift, finding resident #001 minutes after, in the identified room, unattended, in a specific position, and attached to a mobility device.

The following non-compliance issues were identified in this report specific to resident #001:
-FLTCA, 2021, s. 24 (1) Duty to protect.
-FLTCA, 2021, s. 82 (6) 2 Training.
-O. Reg. 246/22, s.40 Transferring and positioning techniques.
-O. Reg. 246/22, s. 55 (2) (b) (iv) Skin and wound care.
-O. Reg. 246/22, s. 111 (1) Complaints – reporting certain matters to Director.

By failing to ensure that resident #001 was not neglected by staff when they were left unattended and attached to a mobility equipment, by failing to ensure that proper transfer techniques and equipment were used when assisting the resident, and by failing to ensure their impaired skin was reassessed, resident #001 was placed at high risk of physical discomfort, health risks and emotional distress.

Sources: LTCH's camera footage, and interview with staff.

This order must be complied with by May 9, 2025

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.