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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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 24, 2019	2019_595110_0013	021096-19	Critical Incident System

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 2P6

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

DIANE BROWN (110)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 2, 3 and 4, 2019.

The Critical Incident inspected related to an allegation of staff to resident abuse.

During this inspection the Inspector conducted record reviews, resident observation and interviews along with a review of relevant polices.

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care, Behavior Support Manager, Life Enrichment Aide, Personal Support Workers and Visitor.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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 failed to ensure that care set out in the plan of care is provided to the resident as specified in the plan.

The Ministry of Long Term Care received a critical incident (CI) reporting an allegation of abuse involving staff #001 towards resident #001.

The source of the allegation was an email sent to the Executive Director by a visitor. The visitor alleged they witnessed and overheard staff #101 reacted inappropriately when interacting with resident #001.

An interview with the identified visitor revealed awareness of resident #001's known behaviors and described how staff #101 inappropriately responded to resident #001's behaviors.

The resident’s written plan of care, included a focus related to the resident's identified responsive behaviors and interventions .

An interview with PSW #102 confirmed that resident #001 had been their primary assignment for a year and they worked the evening of the visitors complaint. The PSW identified that resident #001 had responsive behaviors and interventions. The PSW stated that they had observed one incident that shift whereby staff #101 had interacted with resident #001 in a manner not in keeping with the interventions in the resident's plan of care.

An interview with staff #101 confirmed that two incidents occurred involving resident #001 that shift. Staff #101 stated the first incident was witnessed by PSW #102. The second incident was described in the same location as identified by the visitor. Staff #101 described their interaction with resident #001 and acknowledged that they had not followed the resident plan of care on those two occasions.

An interview with the Behavior Support, Manager #104 confirmed that resident #001 had responsive behaviors and that the resident’s plan of care had not been followed by staff #101 on two occasions. [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 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The Licensee failed to protect residents from abuse by anyone and ensure that residents are not neglected by the licensee or staff

The Ministry of Long Term Care received a critical incident (CI) reporting an allegation of abuse involving staff #001 towards resident #001.

The source of the allegation was an email sent to the Executive Director by a visitor. The visitor alleged they witnessed and overheard staff #101 reacting inappropriately when interacting with resident #001.

An interview with the visitor revealed awareness of resident #001's known behaviors and described how staff #101 responded to resident #001's behaviors.

An interview with staff #101 described their interaction with resident #001 that identified shift and acknowledged that their approach towards the resident was a tactic to manage a behavior but realized standing back that it was abusive to the resident.

An interview with the visitor commented that resident #001 appeared “disheveled” after the interaction with staff #101. An interview with PSW #102 identified that resident #001 did not appear any different that evening shift after the incident, when they assisted the resident with evening care and placed the resident to bed.

An interview with the Behavioral Support Manager #104 identified that the resident does have a memory deficient however the manner in which staff #101 interacted with resident #001 could have had an immediate impact to the resident. The Manager stated the interaction was considered abuse towards resident #001.

The licensee failed to protect resident #001 from abuse. [s. 19. (1)]

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 protect residents from abuse by anyone and ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

Issued on this 2nd day of January, 2020

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

Original report signed by the inspector.