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

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Original Public Report

Report Issue Date September 27, 2022
Inspection Number 2022_1079_0003
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
VH (No. 1) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)

Long-Term Care Home and City
Craiglee Nursing Home, Scarborough,

Lead Inspector
Slavica Vucko (210)

Inspector Digital Signature
Slavica Vucko Digitally signed by Slavica Vucko Date: 2022.09.27 11:59:42 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 31, September 1, 2 and 6, 2022.

The following intake(s) were inspected:

- Intake # 013054-22 related to prevention of abuse, mandatory reporting and discharge

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

- Admission, Absences & Discharge
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION- REPORTING CERTAIN MATTERS TO DIRECTOR

NC#01 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 a person who had reasonable grounds to suspect abuse of resident #002 by resident #001 immediately reported the suspicion to the Director.

Rationale and Summary

On a specified date, resident #001 approached resident #002 and touched them inappropriately. Staff #103 reported the incident to one Registered Practical Nurse (RPN), who further reported the incident to another RPN. This witnessed incident was not reported to the Director until the following day.

Staff were expected to report to management who would report the suspected abuse to the Director.

The management was not informed about the alleged sexual abuse of resident #002 until the next day. The home reported the incident to the Director one day later.

Sources: Critical Incident System (CIS) report, interviews with staff, residents' clinical records. 210

WRITTEN NOTIFICATION-PREVENTION OF ABUSE AND NEGLECT

NC#02 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 residents #002, #003 and #004 were protected from abuse by resident #001.

Rationale and Summary

As per O. Reg 226/22, s. 2.(1) "sexual abuse" means, subject to subsection (3), any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

On a specified date, resident #001 approached resident #002 and touched them inappropriately. Resident #001 was cognitively intact and resident #002 was cognitively impaired.

Because the above-mentioned incident was not reported immediately to the management of the home, interventions to monitor resident #001 were not initiated until the next day. The strategies initiated by Staff #104 for staff to monitor resident 001's behaviour were not effective to protect co-residents from resident #001's behaviour.

The day after the initial incident, resident #001 attempted to touch resident #003 inappropriately, but resident #003 was able to react and stop the act.

Shortly after, resident #001 went into resident #002's room, and was removed by Staff #129, who noted resident #001 was touching resident #002 inappropriately.

Resident #004 reported to the home that earlier that day, resident #001 entered their room and made verbally inappropriate statements to them. Resident #004 was able to prevent any inappropriate touching.

Resident #001 attempted to go close to other residents but was prevented by staff.

Residents #002, #003 were not protected from resident #001's sexual abuse. Resident #004 was distressed because of resident #001's verbally inappropriate behaviour.

Sources: Critical Incident System (CIS) report, interviews with staff, residents' clinical records. 210

WRITTEN NOTIFICATION-DISCHARGING A RESIDENT

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 *s. 161 (2) (b)*

The licensee has failed to ensure that before discharging resident #01 under subsection 157 (1), in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident.

Rationale and Summary

Resident #001 was absent from the home for several days and it was unknown when they would be able to return. A letter discharging resident #001 from the home was prepared by the home's physician several days after the absence. The letter notified the resident they were being discharged from the home as the home was no longer able to meet their care needs and to ensure the safety and security of other residents in the home.

A copy of the discharge letter was sent to the care coordinator of the Local Health Integration Network (LHIN) without alternative arrangements for resident #001's accommodation.

One week later, resident #001 arrived at the home to obtain their personal belongings. Their personal hygiene at the time was noted to be poor. They reported to the Social Worker (SW) that accommodation in the community was not available to them. Resident #001's whereabouts at the time of inspection were unknown both to the home and the placement coordinator at the LHIN.

Failure the home to make alternative arrangements for resident #001's accommodation, care and secure environment, in collaboration with the appropriate placement co-ordinator and other health service organizations, led to unresolved living status of the resident.

Sources: review of resident #001's clinical record, Critical Incident System (CIS) report, interviews with staff.