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 West District**
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# Public Report

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| **Report Issue Date:** December 20, 2024 |
| **Inspection Number:** 2024-1541-0005 |
| **Inspection Type:**<br>Critical Incident |
| **Licensee:** Corporation of the County of Dufferin |
| **Long Term Care Home and City:** Dufferin Oaks, Shelburne |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 17-20, 2024.

The following intake(s) were inspected:

- Intake: #00127956 - staff-to-resident neglect.
- Intake: #00131477 - staff-to-resident verbal abuse.
- Intake: #00132498 - resident-to-resident physical abuse.
- Intake: #00132879 - resident-to-resident physical abuse.

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

Continence Care
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints

# 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)**
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 protect a resident from verbal abuse by a staff member.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act,

"verbal abuse" means,

(a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident,

A Registered Practical Nurse (RPN) witnessed a staff member raise their voice at a resident to find their seat during a mealtime. The resident was described as being visibly unsettled and disoriented after the incident.

**Sources:** Critical incident report, homes investigation folder and abuse policy, and interviews with staff.

## WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 28 (1) 2.**
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

In accordance with FLTCA s. 154 (3), where a staff member has not complied with subsection 28 (1), the licensee shall be deemed to have not complied with the relevant subsection.

1. The licensee has failed to immediately report a suspicion of abuse towards a resident to the Director.

A physical altercation between two residents took place which resulted in injury. The home was required to submit the Critical Incident Report to the Director immediately, however it was not reported until the next day.

**Sources:** The dates outlined in the submitted INFOLINE/Critical Incident Report, the home's documented Critical Incident assessment, and a resident's progress notes.

2. The licensee has failed to immediately report a suspicion of abuse towards a resident to the Director.

A Registered Practical Nurse (RPN) observed an incident of staff-to-resident verbal abuse. The RPN reported the incident in the evening, and the home submitted the

Critical Incident Report related to alleged abuse the next day to the Director.

**Sources:** The dates outlined in the Critical Incident Report and the documented investigation of alleged abuse, email in the home's investigation of the incident, and an interview with staff.

## WRITTEN NOTIFICATION: Continence care and bowel management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 56 (2) (d)**
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

The licensee has failed to ensure that a resident, who was frequently incontinent of urine, received timely assistance from staff to be toileted to promote continence. The resident was not provided assistance with toileting until after using the call bell a third time, which caused them to be upset at the delay in care, and resulted in an incontinent episode.

**Sources:** Interview with staff, call bell logs, and resident's clinical notes.