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

London Service Area Office
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
LondonSAO.moh@ontario.ca

Original Public Report

Report Issue Date July 14, 2022
Inspection Number 2022_1327_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Extendicare Canada Inc.

Long-Term Care Home and City
Extendicare Southwood Lakes, Windsor

Lead Inspector
Debra Churcher #670

Debra Churcher
Digitally signed by Debra Churcher
Date: 2022.07.14 14:03:09 -04'00'

Additional Inspector(s)
Cassandra Taylor #725
Inspector #740915 (Jennifer Bertolin) was also present for this inspection.

INSPECTION SUMMARY

The inspection occurred on the following date(s): The inspection occurred on the following date(s): Onsite May 20, 24, 25, 26, 31, June 1, 2, and 7, 2022. Offsite May 19, June 3 and 6, 2022. This Inspection was completed concurrently with inspection #2022_1327_0002. IPAC was inspected with inspection #2022_1327_0002.

The following intake(s) were inspected:
-Log#006672-22 CIS#2842-000010-22 related to alleged staff to resident sexual abuse.

The following **Inspection Protocols** were used during this inspection:
-Prevention of Abuse and Neglect

INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable. There were findings of non-compliance.

WRITTEN NOTIFICATION: IMMEDIATE REPORTING OF SUSPECTED ABUSE

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NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 24. (1) 2.

The licensee has failed to ensure that any person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 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.

Rationale and Summary:
The home submitted a Critical Incident System Report (CIS) alleging staff to resident abuse. The CIS was submitted the day after the abuse was alleged to have occurred and no call to the Ministry of Long-Term Care (MLTC) after-hours line was made.

During an interview with the Director of Care (DOC) they stated that they became aware of the alleged abuse from reading report when they arrived in the morning on the day after the abuse was alleged to have occurred. The DOC stated that the Registered Nurse (RN) on duty at the time of the alleged abuse did not notify the manager on call of the alleged abuse and should have so they could have done any required notifications.

During an interview with the RN they stated they would not normally contact the MLTC after-hours line as they are supposed to contact the manager on-call and they would usually do the notification. The RN stated that they did not notify the on-call Manager.

Sources:
CIS report, interviews with the DOC and RN on duty at the time of the alleged abuse.

[#670]