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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Waterloo, ON, N2V 1K8
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Original Public Report

Report Issue Date: November 29, 2023
Inspection Number: 2023-1579-0003
Inspection Type: Critical Incident
Licensee: Corporation of the County of Grey
Long Term Care Home and City: Rockwood Terrace Home for the Aged, Durham

Lead Inspector	**Inspector Digital Signature**
Dianne Tone (000686)	Dianne Elizabeth Tone Digitally signed by Dianne Elizabeth Tone Date: 2023.12.14 11:40:22 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 15-16, 20-22, 2023

The following intake(s) were inspected:

- Intake: #00090172 - Staff to Resident abuse.

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

Infection Prevention and Control
Prevention of Abuse and Neglect

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 failed to protect resident from verbal abuse by a staff member.

In accordance with O. Reg. 246/22, s. 2 (1) Verbal abuse means, 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.

Rationale and Summary:
A Personal Support Worker (PSW) witnessed a staff member verbally abuse four residents.

One of the residents stated that the staff member was mean to them.

The staff member acknowledged that their communication was inappropriate.

When the staff member verbally abused residents it negatively impacted the

residents.

Sources: Critical Incident Report, Home investigation notes, Interviews with Director of Care and PSW.

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WRITTEN NOTIFICATION: Reporting Certain Matters to the 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.

The Licensee failed to ensure that a Personal Support Worker immediately reported an allegation of verbal abuse of residents.

In accordance with FLTCA, 2021, s. 154 (3), the licensee is vicariously liable for a staff member failing to comply with subsection 28 (1).

Rationale and Summary:
The home reported an allegation of abuse, late, to the Director.

Director of Care (DOC) stated that staff are to immediately report an allegation of

abuse to the charge nurse. The charge nurse would then respond immediately and report it to the on-call manager.

A PSW did not report an allegation of abuse to their charge nurse immediately. As a result, the alleged abuser continued to work the rest of their shift and the Director was notified late.

When the PSW did not report the allegation of abuse immediately to their charge nurse it prevented the home from responding and reporting immediately, putting more residents at risk.

Sources: Interview with DOC, a PSW, Review of Critical Incident, and home's investigation notes.
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