Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central West District
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Original Public Report

Report Issue Date: December 6, 2022

Inspection Number: 2022-1109-0001

Inspection Type:
Critical Incident System

Licensee: Southampton Care Centre Inc.

Long Term Care Home and City: Southampton Care Centre, Southampton

Lead Inspector	**Inspector Digital Signature**
Janis Shkilnyk (706119)	Janis M Shkilnyk Digitally signed by Janis M Shkilnyk Date: 2022.12.08 10:31:45 -05'00'

Additional Inspector(s)
Janet M Evans (659)
Kaitlyn Puklicz (000685) was also present during this inspection

INSPECTION SUMMARY

The Inspection occurred on the following date(s): November 28-December 1, 2022

The following intake(s) were inspected:

Log: #00001027 related to abuse of a resident with injury

Log: #00001585, #00003260, #0000674 related to a fall of a resident with injury.

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

Responsive Behaviours
Falls Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Skin and Wound Prevention and Management

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)
The licensee has failed to ensure that a resident was protected from abuse by another resident. "Physical abuse" is defined as the use of physical force by anyone other than a resident that causes injury or pain. O. Reg. 246/22, s. 2 (1).

Rationale and Summary
On a specified date, resident #001 entered resident #005's room and hit them causing injury. Resident #001 was required to have one to one monitoring in place at the time of the incident due to specific behaviors but did not.

The Director of Care (DOC) confirmed that the home's internal investigation outcome concluded that resident #005 had been physically abused by resident #001.

This incident of physical abuse caused actual harm to resident #005 as they did sustain physical injuries and resident #005 was emotionally distressed and fearful when the incident occurred.

Sources:
Review of resident #001 and #005's clinical records, interviews with DOC, Registered Practical Nurse (RPN) #111, Personal Support Worker (PSW) #107, Southhampton Care Center internal investigation. [706119]

WRITTEN NOTIFICATION: Duty of Licensee to Comply With Plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCH, 2021 s.6 (7)
The licensee has failed to ensure that resident #001 received constant monitoring as outlined in the resident's plan of care.

Rationale and Summary
Resident #001's plan of care indicated they were to be one to one monitoring due to specified behaviours.

On a specified date, resident #001 entered resident #005's room and hit them causing injury. Resident #001 did not have one to one monitoring in place at the time of the incident, as required by their plan of care.

Failing to follow resident #001's plan of care with respect to one-to-one monitoring led to actual harm to resident #005.

Sources:
Action Line, resident #001 clinical record review and care plan, interview with DOC.
[706119]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
The licensee has failed to ensure that an assessment was completed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, when resident #005 experienced altered skin integrity.

Rationale and Summary
A skin and wound assessment was not completed by a member of the registered nursing staff using a clinically appropriate assessment instrument when resident #005 experienced altered skin integrity. The Director of Care confirmed that an initial skin and wound assessment was not completed for the resident in relation to their altered skin integrity.

The home’s failure to complete a skin and wound assessment for resident #005 when altered skin integrity was identified could have impacted treatment and thus the healing of the skin condition.

Sources:
Resident #005’s clinical records, resident #005’s head to toe assessment, interview with DOC.
[706119]

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