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

**Ottawa District**
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

# Original Public Report

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| **Report Issue Date: April 26, 2023** |
| **Inspection Number:** 2023-1019-0002 |
| **Inspection Type:**<br>Critical Incident System |
| **Licensee:** 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership |
| **Long Term Care Home and City:** West Lake Terrace, Picton |

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| **Lead Inspector**<br>Ashley Bernard-Demers (740787) | **Inspector Digital Signature**<br>Ashley F Bernard -Demers Digitally signed by Ashley F Bernard-Demers Date: 2023.04.27 10:51:54 -04'00' |

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| **Additional Inspector(s)** |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 17-21, 2023

The following intake(s) were inspected:

- Intake: #00017823 - CIR #0997-000001-23 - Unexpected death
- Intake: #00018116 - CIR #0997-000002-23 - Staff to resident alleged abuse
- Intake: #00018774 - CIR #0997-000003-23 - Unwitnessed fall with injury

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Policy to promote zero tolerance

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

Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee failed to comply with their written policy to promote zero tolerance of abuse and neglect of residents.

**Rationale and Summary**
A critical incident report (CIR) was submitted to the Ministry of Long-Term Care (MLTC) regarding allegations of staff to resident abuse.

A review of the licensee investigation file into the incident of staff to resident alleged abuse, revealed that the incident occurred on a day in January 2023, but was not reported to the MLTC immediately.

A review of the licensee's policy Zero Tolerance of Abuse and Neglect of Residents, indicated that any person who has reasonable grounds to suspect that a resident has been neglected or abused is obligated by law to immediately report the suspicion and the information upon which the suspicion is based to the Director, the Home's Administrator or manager on call.

It was confirmed by the Administrator that a personal support worker (PSW) witnessed the alleged abuse, but did not report it immediately.

Failing to comply with the licensee's policy regarding Zero Tolerance of Abuse and Neglect of Residents places residents at risk of harm.

**Sources:** Investigation file; Policy: Zero Tolerance of Abuse and Neglect of Residents; and an interview with the Administrator

[740787]

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