

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

Hamilton District

119 King Street West, 11th Floor Hamilton, ON, L8P 4Y7 Telephone: (800) 461-7137

	Original Public Report
Report Issue Date: May 6, 2024	
Inspection Number: 2024-1618-0002	
Inspection Type:	
Critical Incident	
Licensee: The Regional Municipality of Halton	
Long Term Care Home and City: Creek Way Village, Burlington	
Lead Inspector	Inspector Digital Signature
Emma Volpatti (740883)	
Additional Inspector(s)	
-	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 24, 26, 29, 2024.

The following intake(s) were inspected:

• Intake #00093194 (Critical Incident (CI) #M623-000016-23) related to the prevention of abuse and neglect.

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

Infection Prevention and Control Prevention of Abuse and Neglect



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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 ensure that a resident was protected from abuse by another resident.

Rationale and Summary

A PSW observed resident A inappropriately touching resident B. The PSW immediately separated both residents.

Review of the Critical Incident (CI) report submitted by the home indicated that resident B did not have the capacity to consent to the encounter.

A Manager of Resident Care acknowledged that the incident met the definition of abuse, as resident B was inappropriately touched by resident A without their consent.

Failing to protect resident B posed a risk of potential harm.

Sources: CI report, interview with a PSW and other staff, clinical records. [740883]