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**
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# Public Report

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| **Report Issue Date:** April 16, 2025 |
| **Inspection Number:** 2025-1488-0003 |
| **Inspection Type:**<br>Critical Incident |
| **Licensee:** Centre d'Accueil Roger Seguin |
| **Long Term Care Home and City:** Centre d'Accueil Roger Seguin, Clarence Creek |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 9, 10, 15, 2025

The following intake(s) were inspected:

- Intake #00141361 (CIS #2988-000011-25), intake #00141932 (CIS #2988-000014-25), intake #00142235 (CIS #2988-000015-25), and intake #00144756 (CIS #2988-000021-25) related to alleged resident to resident abuse.

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

Responsive Behaviours
Prevention of Abuse and Neglect

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Prevention of Abuse

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 anyone.

A resident displayed on three occasions specified inappropriate behaviours toward a co-resident while the resident was seated in identified home areas. The co-resident's plan of care directed staff to place the resident in a different care area, but the resident was not seated consistently in that care area during those occasions.

**Sources**: Inspector's observation. A resident's progress notes, plan of care. Director of Care's email to staff. Interviews with staff members.

## WRITTEN NOTIFICATION: Responsive Behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)**
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that, for a resident demonstrating responsive

behaviours, the resident's responses to interventions were documented.

A day in March 2025, a resident exhibited inappropriate behaviours toward a co-resident, and a specified documentation was initiated. Review of the completed documentation record showed that staff had not consistently documented during numerous shifts for the identified period.

**Sources:** A resident's progress notes and DOS documentation. Interview with a staff member.