Ontario

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

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

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Original Public Report

Report Issue Date July 15, 2022
Inspection Number 2022_1091_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Southbridge Health Care GP Inc. and Southbridge Care Homes

Long-Term Care Home and City
Country Village Homes, Woodslee

Choose an item.
Samantha Perry #740

Inspectors Christie Birch #740898 and Karen Honey #740899 were also present during this inspection.

Inspector Digital Signature
Samantha Perry
Digitally signed by Samantha Perry
Date: 2022.07.15 14:51:10 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 22, 23, 24, 27, 28, and 29, 2022.

The following intake(s) were inspected:

- #005167-22 CIS # 2576-000008-22 related to alleged sexual abuse,
- #009237-22 CIS # 2576-000013-22 related to transferring and repositioning,
- #005529-22 Follow-Up inspection related to order #001 from inspection #2022_791739_0010 related to 24hr admission care plans.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	s. 24	2022_791739_0010	001	Samantha Perry #740

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

- Admission, Absences & Discharge
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Reporting and Complaints

- Resident Care and Support Services
- Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION REPORTING CERTAIN MATTERS TO DIRECTOR

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA 2007 s. 24. (1)2.

The licensee has failed to ensure that when staff had reasonable grounds to suspect abuse, it was immediately reported with the information upon which it was based, to the Director.

Rationale and Summary
The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) Report related to alleged sexual abuse.

An incident involving a resident occurred and the following was reported by the resident. A strange Personal Support Worker (PSW) entered their room, tried to provide care without introducing themselves, and the resident felt very violated by this. Assistant Director of Care (ADOC) #100 further discussed the incident with the resident, and the resident expressed continued displeasure with their interaction with the PSW.

In an interview ADOC #100 said, there were reasonable grounds to suspect sexual abuse and the suspicion and the information upon which it was based should have been immediately reported to the Director.

The risk to the resident was increased when the licensee had reasonable grounds to suspect sexual abuse and failed to immediately report their suspicions to the Director.

Sources:
CIS report, the home's investigation notes, the resident's clinical records and interviews with the resident, staff and management.