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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: June 13, 2023	
Inspection Number: 2023-1386-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: The Village of Taunton Mills, Whitby	
Lead Inspector Julie Dunn (706026)	**Inspector Digital Signature**
Additional Inspector(s) Rexel Cacayurin (741749)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 23 - 26 and 29 - 31, 2023

The following intake(s) were inspected:
- Intake #00002625 – related to a complaint regarding falls prevention and management.
- Intake #00006578 – related to a complaint regarding skin and wound care, oral care, and responsive behaviours.
- Intake #00086478 – related to a complaint regarding plan of care and neglect.
- Intakes #00004054, #00004537, #00018355, #00087482, and #00088026 related to responsive behaviours.
- Intake #00013308 related to falls prevention and management and Intake #00085759 related to an injury with a significant change in condition.
- Intake #00006822 related to an allegation of staff to resident abuse.
- Intake #00086309 related to an allegation of neglect.

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

Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls 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 failed to ensure that a resident was protected from abuse.

Section 2 of the Ontario Regulation 246/22 defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Rationale and Summary
A Critical Incident Report (CIR) was submitted to the Director related to an allegation of resident-to-resident abuse. The CIR indicated that staff witnessed a resident-to-resident incident.

In an internal investigation document, a Personal Support Worker (PSW) indicated that upon entering a resident's room, they witnessed a resident-to-resident incident. The two residents were immediately separated.

A Registered Practical Nurse (RPN) stated that the witnessed incident was reported to them by the PSW. The Behavioural Supports Ontario (BSO) Lead stated that they considered it to be a sexual abuse incident. Further, the BSO Lead indicated there was a previous history of similar incidents for one of the residents.

The Director of Care (DOC) stated that sexual abuse was founded as a result of the long-term care home's internal investigation. The DOC also indicated that there was an incident of similar nature in the past with both residents.

The PSW, RPN, BSO Lead and DOC acknowledged that a resident was incapable of giving consent.

Failure to protect a resident from sexual abuse by another resident resulted in moderate impact to the resident's safety, dignity, quality of life and increased risk of further incidents.

Sources: Critical Incident Report, long-term care home's internal investigation documents, interviews with staff.
[741749]