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

Central West District
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Public Report

Report Issue Date: December 4, 2024

Inspection Number: 2024-1703-0005

Inspection Type:
Critical Incident

Licensee: CVH (No. 3) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)

Long Term Care Home and City: Southbridge Owen Sound, Owen Sound

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 25-28, 2024

The following intake(s) were inspected:

- Intake: #00125514 - IL-0130606-AH/3061-000057-24 alleged staff to resident physical abuse
- Intake: #00129862 - IL-0132651-AH/3061-000064-24 - Alleged neglect of resident by staff

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

Infection Prevention and Control
Prevention of Abuse and Neglect

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 failed to protect a resident from physical abuse by a Personal Support Worker (PSW).

Ontario Regulation 246/22 s. 2 (1) defines physical abuse as (c) the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary
A resident had injuries when a personal support worker (PSW) hit them with an object. The resident healed with no emotional effects.

The Executive Director (ED) confirmed that the PSW did physically abuse the resident and that the PSW has been terminated.

Failure to protect the resident from the PSW resulted in actual harm.

Sources: resident clinical record, investigation notes, Critical incident and interviews with ED, and other staff.

WRITTEN NOTIFICATION: General requirements

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that actions taken with respect to a resident under the continence care program, including interventions and the resident's responses to interventions, were documented for a resident.

Rationale and Summary
A Personal support worker (PSW) did not document when a resident declined care and did document when other PSW staff provided that care.

The Executive Director stated that PSW falsified documentation when they did not chart that a resident refused care and charted that they completed care that was completed by another staff member.

When the PSW inaccurately documented whether an intervention was provided and the residents' response it, it was difficult to track and determine the effectiveness of the intervention.

Sources: Resident clinical record, interviews with PSW and other staff