

Ministry of Long-Term Care

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

Ottawa District

347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Public Report

Report Issue Date: October 8, 2025
Inspection Number: 2025-1523-0007
Inspection Type: Complaint Critical Incident
Licensee: The Ottawa Jewish Home for the Aged
Long Term Care Home and City: Hillel Lodge, Ottawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 29, 2025 and October 1, 3, 6-8, 2025

The following intake(s) were inspected:

- Intake: #00153925 - Complainant with concerns regarding the death of a resident.
- Intake: #00154013 - CIR #3029-000026-25 - Alleged resident to resident sexual abuse.
- Intake: #00155089 - CIR #3029-000027-25 - Fall of a resident resulting in injury .
- Intake: #00155708 - Complaint related to an allegation of staff to resident neglect.
- Intake: #00157709 - CIR #3029-000035-25 - Missing resident.
- Intake: #00158411 - CIR #3029-000039-25 - Alleged resident to resident sexual abuse.
- Intake: #00158442 - CIR#3029-000040-25 -Alleged resident to resident sexual abuse.

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

Resident Care and Support Services
Prevention of Abuse and Neglect
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)

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 sexual abuse by another resident.

Sexual abuse means "any non-consensual touching, behavior or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member".

On a specify day in 2025, during a specific shift, the resident exhibited inappropriate sexual behavior towards a resident. On the same day, different shift. the resident exhibited inappropriate sexual behavior towards another resident. The staff were aware that the resident exhibited inappropriate sexual behaviors and did not implement close monitoring to protect the other resident.

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Sources: Critical Incidents, progress notes and interviews with Assistant Directors of Care.