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

Toronto District
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Original Public Report

Report Issue Date: September 18, 2023	
Inspection Number: 2023-1238-0009	
Inspection Type: Critical Incident	
Licensee: North York General Hospital	
Long Term Care Home and City: Seniors' Health Centre, North York	
Lead Inspector Arther Chandramohan (000720)	**Inspector Digital Signature** Arther Chandramohan Digitally signed by Arther Chandramohan Date: 2023.09.19 10:23:44 -04'00'
Additional Inspector(s) Fiona Wong (740849)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 11-13, 2023.

The following intake(s) were inspected:

- Intake: #00014482 - 2744-000203-22. Critical Incident: resident to resident sexual abuse.
- Intake: #00093404 - 2744-000025-23. Critical Incident: resident fall resulting in injury.

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

Infection Prevention and Control
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)

The licensee has failed to ensure that resident #003 was protected from abuse by resident #002.

Section 2 (1) (b) 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
On a specified date, Personal Support Worker (PSW) #105 and PSW #106 witnessed sexual behaviour from resident #002 directed towards resident #003.

The home’s prevention of abuse and neglect policy states that the organization has a zero-tolerance policy for abuse of a resident by anyone.

A Registered Practical Nurse (RPN) and the Director of Care (DOC) stated that resident #003 did not have the ability to consent to resident #002’s actions.

PSW #105, PSW #106, the RPN, and the DOC indicated that sexual abuse occurred.

There was risk of emotional impact to resident #003 when they were sexually abused by resident #002.

Sources: resident #002's progress notes, the home’s investigation notes, interviews with PSW #105, PSW #106, the RPN, and the DOC, and the home’s prevention of abuse and neglect policy.

[740849]