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

Ottawa District
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Public Report

Report Issue Date: August 21, 2025
Inspection Number: 2025-1620-0005
Inspection Type: Critical Incident
Licensee: County of Lennox and Addington
Long Term Care Home and City: The John M. Parrott Centre, Napanee

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 14, 19, 20, 21, 2025

The following intake(s) were inspected:

- Intake: #00150986 - CIR #M625-000038-25 - related to alleged emotional abuse and neglect of residents by a staff member.
- Intake: #00154370 - CIR #M625-000042-25 - related to a medication incident involving a resident.
- Intake: #00154360 - CIR #M625-000041-25 - related to a fall of a resident resulting in an injury.

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

Medication Management
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to immediately report to the Director the suspicion of alleged abuse and neglect of residents by a staff member.

During an interview with the Inspector, the Manager of Nursing (MON) indicated that multiple staff had reported incidents of alleged neglect and abuse of four residents by a PSW to the RPN on duty. The RPN did not report the incidents to management until eight days later. The documentation by the RPN indicated that allegations against the PSW extended over a two-week period. A critical incident report (CIR) was not submitted to the Director until two days after the RPN submitted the information to management.

Sources: CIR #M625-000038-25; Interview with MON; email documentation of incidents.