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
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559
ottawadistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: January 6, 2023	
Inspection Number: 2022-1063-0002	
Inspection Type: Critical Incident System	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare New Orchard Lodge, Ottawa	
Lead Inspector Laurie Marshall (742466)	**Inspector Digital Signature** Laurie R Marshall Digitally signed by Laurie R Marshall Date: 2023.01.06 11:55:08 -05'00'
Additional Inspector(s) Sarah Stephens (740823)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 6 to December 9, 2022
The following intake(s) were inspected:
Intake: #00005799 [CI: 2302-000009-22] Alleged sexual abuse of a resident by staff.
Intake: #00009211 [CI: 2302-000012-22] Fall of a resident resulting in injury.

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

Infection Prevention and Control
Falls Prevention and Management
Prevention of Abuse and Neglect

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by staff that resulted in harm or a risk of harm to the resident had occurred or may occur, immediately reported the suspicion and the information upon which it is based to the Director.

Rationale and Summary:

The homes internal investigation reported that staff had a conversation with resident in which they became aware of alleged sexual abuse towards a resident by another staff member. Interviews with staff involved in reporting indicated that reporting of alleged sexual abuse was not reported until two weeks after the occurrence.

Interview with Director of Care (DOC) indicated that staff who spoke to the resident regarding alleged sexual abuse did not report. The home became aware of the allegations when another staff member had reported to their Manager upon which the home immediately reported to the Director.

Failure to immediately report alleged abuse delayed investigation and interventions to ensure the safety of the resident.

Sources: Internal investigation documents, critical incident report, interviews with DOC and other staff. [740823]

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