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

# Original Public Report

| | |
|---|---|
| **Report Issue Date:** April 13, 2023 | |
| **Inspection Number:** 2023-1482-0002 | |
| **Inspection Type:**<br>Complaint<br>Critical Incident System | |
| **Licensee:** Lennox and Addington County General Hospital Association | |
| **Long Term Care Home and City:** Lennox and Addington County General Hospital, Napanee | |
| **Lead Inspector**<br>Wendy Brown (602) | **Inspector Digital Signature**<br>Wendy K Brown<br>Digitally signed by Wendy K Brown<br>Date: 2023.10.05 11:01:17 -04'00' |
| **Additional Inspector(s)** | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 5 - 6, 2023

The following intake(s) were inspected:

- Intake: #00020142/CIS #7089-000002-23 – regarding suspected resident to resident sexual abuse.
- Intake: #00020817 – Complaint regarding follow-up on suspected resident to resident sexual abuse.

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

Prevention of Abuse and Neglect

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Reporting and Complaints

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

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

Staff responded to a resident bed alarm and found the resident laying in their bed with their brief and sheets pulled aside and their groin area exposed. The bed rail was in the down position and a co-resident was sitting beside the resident's bed. The Critical Incident System (CIS) report indicated that the resident laying in bed was physically unable to pull down their covers, lower the bedrail or remove their brief. The co-resident advised staff that they had been having a chat and returned to their bed. The resident was provided care and support and settled back to sleep. Close monitoring noted no further incidents for the remainder of the night.

Staff contacted the night on call Administrator and were advised that the Nurse Manager would be made aware in the morning, that there was no need to contact the police and no further action was required. During interviews, the Assistant Director of Care (ADOC)/Nurse Manager and the DOC/Chief Nursing Officer acknowledged that the Director should have been immediately notified of the suspected resident to resident sexual abuse.

The risk associated with not immediately informing the Director of suspected abuse is that this could place residents at risk of additional harm.

**Sources:**
Interviews with ADOC/Nurse Manager and the DOC/Chief Nursing Officer, and review of the CIS report and resident progress notes.

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