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

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Public Report

Report Issue Date: April 17, 2025
Inspection Number: 2025-1380-0001
Inspection Type: Complaint Critical Incident
Licensee: Deep River and District Health
Long Term Care Home and City: The Four Seasons Lodge, Deep River

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 14, 15, 16, 17, 2025

The following intake(s) were inspected:

- Intake: #00143225 - Complainant with concerns regarding a co-resident.
- Intake: #00145173 - Respiratory Outbreak.

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that clear directions were documented in a resident 's written plan of care advising of the monitoring system in place to keep a resident safe from another resident entering their space.

Sources: Inspector observations, review of a resident's clinical records, interviews with a resident, and a PSW.

The licensee updated the written plan of care to include documentation regarding the monitoring system to keep a resident safe from another resident entering their space.

Date Remedy Implemented: April 15, 2025

WRITTEN NOTIFICATION: Responsive Behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that when residents exhibit responsive behaviours, they are assessed and reassessed when behaviours change or interventions in place are not effective. Specifically, the home completed two separate DOS mapping tools, in a specified date range in March 2025 for a resident regarding their increase in responsive behaviours. Neither tool was reassessed as per the homes responsive behaviour program to do so, to determine possible outcome actions.

Sources: A resident's DOS mapping, Interview with an RPN and the DOC.

WRITTEN NOTIFICATION: Reporting of Critical Incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to immediately report a respiratory outbreak to the Director that was declared on a specified date in April 2025, via the Critical incident reporting system (CIS). The home submitted the report on a couple days later.

Sources: CIS and interview with the DOC.