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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
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Original Public Report

Report Issue Date: June 5, 2023	
Inspection Number: 2023-1569-0002	
Inspection Type: Critical Incident System	
Licensee: The Board of Management for the District of Manitoulin	
Long Term Care Home and City: Manitoulin Centennial Manor Home for the Aged, Little Current	
Lead Inspector Steven Naccarato (744)	**Inspector Digital Signature** Steven C Naccarato Digitally signed by Steven C Naccarato Date: 2023.06.12 14:43:06 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 8-10, 2023
The inspection occurred offsite on the following date(s): May 15, 2023

The following intake was inspected:

- One intake regarding resident to resident abuse.

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that a resident's specialized device was used as specified in their plan of care.

Rationale and Summary

A resident's plan of care indicated that a specialized device was to be operated in a specific way.

During multiple observations, the resident's specialized device was not operating in the specific way mentioned in their plan of care.

In an interview with the Director of Care (DOC) they indicated that the specialized device of the resident was required to be operated in a specific way to help ensure the safety of residents.

The home's failure to ensure that the resident's specific device operated in a specific way was low risk because certain staff have indicated that the resident did not have the need for the specialized device and alternative measures were in place.

Sources: The resident's electronic health records; Inspector observations; Interviews with the DOC and other staff.
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WRITTEN NOTIFICATION: Police notification

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105

The licensee has failed to ensure that the appropriate police force was immediately notified of an incident of abuse involving two residents.

Rationale and Summary

The Director was notified of an incident of abuse that occurred at the home involving two residents; however; the Director of Care (DOC) did not immediately notify the appropriate police force.

The home's failure to ensure that the appropriate police force was immediately notified of an incident of abuse was minimal risk.

Sources: The critical incident; The home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting (last reviewed January 2022)"; Interviews with the DOC and other staff.

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