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
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: October 25, 2024
Inspection Number: 2024-1569-0003
Inspection Type: Complaint Critical Incident
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 21-25, 2024.

The following intake(s) were completed:

- One intake related to a COVID-19 Outbreak;
- One intake related to an enteric outbreak;;
- One complaint related to care concerns and accommodations; and,
- One intake related to resident to resident physical abuse.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours

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: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with.

In accordance with Additional Requirement 10.2 (c) under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, the licensee has failed to ensure that assistance to residents to preform hand hygiene was provided before a lunch meal service. Further observations of other meal services revealed staff members assisting all residents with hand hygiene prior to the meal service.

Sources: Observations of the lunch meal service; Interviews with a Personal Support Worker (PSW) and Director of Care (DOC):; record review of the Standard for Long-Term Care Homes and Home's policy titled, "Hand Hygiene".

Date Remedy Implemented: October 23, 2024

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #002 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 ensure that the Director was immediately informed of an enteric outbreak as the home reported the outbreak the day after the outbreak was declared.

Sources: Critical Incident System (CIS) report and interview with DOC.

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