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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Original Public Report

Report Issue Date: October 21, 2022	
Inspection Number: 2022-1173-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: 584482 Ontario Inc.	
Long Term Care Home and City: Manitoulin Lodge, Gore Bay	
Lead Inspector Ryan Goodmurphy (638)	**Inspector Digital Signature** Ryan C Goodmurphy Digitally signed by Ryan C Goodmurphy Date: 2022.11.08 12:34:02 -05'00'

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 3 and 4, 2022, with off-site activities occurring October 11-13, 2022.

The following intake(s) were inspected:

- Two intakes which were related to incidents of resident to resident abuse.
- One intake which was related to a medication incident.
- One intake which was a complainant regarding staffing, resident care concerns as well as dietary and housekeeping services.

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

Medication Management
Responsive Behaviours
Responsive Behaviours
Infection Prevention and Control
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when their care needs changed, upon the identification of their responsive behaviours.

A resident demonstrated specific responsive behaviours on multiple occasions. Staff acknowledged the resident's potential to demonstrate these behaviours, however, the types of behaviours known and triggers were not identified within the resident's plan of care to ensure that all staff were aware of the behaviours and how to manage them, as needed.

The lack of identified behaviours within the resident's plan of care placed others at risk of harm if staff were unaware of the behaviours or how to manage them.

Sources: The resident's health care records; interviews with the Administrator, Director of Care and other staff. [638]

WRITTEN NOTIFICATION: Administration of Drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 131 (2)

The licensee has failed to ensure that prescribed drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

A resident required multiple medications at prescribed times throughout each day and it was identified that the resident was missing medications on specific dates. Staff took action in an attempt to obtain the missing medications, however, they did not follow the home's policy to obtain the medications. This resulted in the resident not receiving their prescribed medications on specific dates.

The Administrator and Director of Care identified that they expected the resident to be administered their prescribed medications and that staff had not followed the home's processes to obtain the medications. Staff failed to provide the resident with their prescribed medications which put the resident at risk of adverse effects from missing their prescribed drugs for health management.

Sources: The resident's health care records; emails between the home and the primary pharmacy; emergency medication home supply list; pharmacy policies; interviews with the Administrator, Director of Care and other staff. [638]