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: January 20, 2023	
Inspection Number: 2023-1173-0003	
Inspection Type: Critical Incident System	
Licensee: 584482 Ontario Inc.	
Long Term Care Home and City: Manitoulin Lodge, Gore Bay	
Lead Inspector Shelley Murphy (684)	**Inspector Digital Signature** Shelley Murphy Digitally signed by Shelley Murphy Date: 2023.01.24 14:51:55 -05'00'

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 9-12, 2023

The following intake(s) were inspected:

- One intake related to resident falls.
- One intake related to resident-to-resident abuse.

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

Falls Prevention and Management
Prevention of Abuse and Neglect
Infection Prevention and Control

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)
FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that a resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary

A resident's care plan for behaviours indicated they should have a specific intervention in place.

While observing the resident it was noted that the intervention was not in place.

During a discussion with the Administrator and Director of Care (DOC), the DOC informed the inspector that many new interventions were implemented to ensure all residents' safety.

The DOC further stated that the resident's interventions were re-evaluated and some were removed as they were no longer required.

The risk to other resident's was low.

Sources: Resident care plan, observations of the resident, and the Administrator and DOC interview.
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Date Remedy Implemented: January 10, 2023

WRITTEN NOTIFICATION: Reporting Certain Matter to Director

NC #002 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 when a person who has reasonable grounds to suspect that abuse of a resident had occurred immediately report the suspicion and the information upon which it is based, to the Director.

Upon review of the Critical Incident System report (CIS) it indicated that two separate incidents of abuse had occurred.

During an interview with the Administrator, they stated that when the initial CIS report was submitted they were aware the other incident of abuse had occurred, but they only submitted the one CIS report. It was not until the Administrator spoke to a Ministry of Long-Term Care employee that the Administrator submitted the second CIS report.

The risk to residents as it relates to this non-compliance is low.

Sources: CIS report, home's policy titled: LTC Mandatory Reporting to MOLTC of Critical Incidents, last reviewed October 27, 2022, and the Administrator's interview.
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