

### 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 northdistrict.mltc@ontario.ca

# **Original Public Report**

Report Issue Date: January 5, 2023

Inspection Number: 2022-1483-0001

Inspection Type:

Critical Incident System

Licensee: Autumnwood Mature Lifestyle Communities Inc.	
Long Term Care Home and City: Cedarwood Lodge, Sault Ste. Marie	
Lead Inspector	Inspector Digital Signat

Jennifer Lauricella (542)

Inspector Digital Signature

Additional Inspector(s)

## **INSPECTION SUMMARY**

The Inspection occurred on the following date(s): November 1-4 and 7, 2022

The following intake(s) were inspected:

- One intake related to staff to resident abuse and
- One intake related to responsive behaviours

The following Inspection Protocols were used during this inspection:

Prevention of Abuse and Neglect Responsive Behaviours Infection Prevention and Control



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## **INSPECTION RESULTS**

#### WRITTEN NOTIFICATION: Prevention of Abuse Policy

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1. Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure that their Zero Tolerance of Abuse and Neglect policy was complied with by a staff member.

#### **Rationale and Summary**

A Critical Incident (CI) report was submitted to the Director, outlining the alleged abuse towards a resident by a staff member

A review of the home's internal investigation documents concluded, that a staff member witnessed abuse by another staff member towards a resident. The staff member that witnessed the abuse failed to report the abuse until the end of their shift.

The Administrator indicated that the abuse was founded, and that the home's staff were to report the abuse immediately.

The failure to report the abuse immediately placed the residents at a risk towards their health, safety and well-being.

Sources: CI #7093-000007-22 report; the licensee's investigation documents and policy on "Zero tolerance to resident abuse and neglect" and interview with the home's Administrator.