

Inspection Report Under the Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care

Long-Term Care Operations Division Long-Term Care Inspection Branch Sudbury Service Area Office 159 Cedar St, Suite 403 Canada, ON, P3E 6A5 Telephone: (800) 663-6965

SudburySAO.moh@ontario.ca

Report Issue Date: November 9, 2022 Inspection Number: 2022-1569-0001 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 Amy Geauvreau (642) Additional Inspector(s)

INSPECTION SUMMARY

The Inspection occurred on the following date(s): September 26-28, 2022.

The following intake(s) were inspected:

• Two Intakes: related to a fall of a resident, resulting in an injury.

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

Falls Prevention and Management Falls Prevention and Management Infection Prevention and Control

INSPECTION RESULTS



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WRITTEN NOTIFICATION: Reports re critical incidents

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (4) (a)

The licensee had failed to contact the hospital within three calendar days to find out if a resident had a significant change in their health status, after a fall with an injury.

A review of a resident's progress notes identified no progress notes were written for the three calendar days.

In an interview with a Registered Nurse (RN), they identified that no nurse had called the hospital over the three days.

Not contacting the hospital for an update within the three calendar days, had no specific effect to the resident, therefore the non-compliance was identified as low risk.

Sources: Critical Incident (CI); resident's progress notes, post fall assessments, hospital discharge summary; Falls Prevention and Management Program, last revised January 2022; interviews with the RN, the Director of Care (DOC), and other staff.

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