Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Sudbury Service Area Office
159 Cedar Street, Suite 403
Sudbury ON P3E 6A5
Telephone: 1-800-663-6965
SudburySAO.moh@ontario.ca

Original Public Report

Report Issue Date September 8, 2022
Inspection Number 2022_1602_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other ______________________

Licensee
Board of Management of the District of Kenora

Long-Term Care Home and City
Northwood Lodge, Red Lake

Lead Inspector
Christopher Amonson (721027)

Inspector Digital Signature

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred on the following date(s): Aug 24 – 29, 2022

The following intake(s) were inspected:

- One intake related to a fall with injury.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 *s. 115 (3)4*

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The licensee has failed to ensure the Director was informed no later than one business day after an incident occurred that caused an injury to a resident resulting in a significant change in the resident's health.

Rationale and Summary

A resident had a fall where they sustained an injury that required further assessment. The resident was transferred to a hospital for treatment of their injury. The Critical Incident report for the fall was submitted four business days after the incident.

The Administrator and DOC stated that the Critical Incident report was submitted late. The Administrator was notified of the resident's diagnosis and change in health status the day after the incident occurred.

There was minimal risk to the resident with the delay in informing the Director, and no documented impact to the resident because of the delayed submission of the report.

Sources: Critical incident report; resident health records; and interviews with DOC and Administrator.

[#721027]