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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: May 3, 2024	
Original Report Issue Date: April 17, 2024	
Inspection Number: 2024-1522-0001 (A1)	
Inspection Type: Critical Incident Follow up	
Licensee: Anson General Hospital	
Long Term Care Home and City: South Centennial Manor, Iroquois Falls	
Amended By Steven Naccarato (744)	**Inspector who Amended Digital Signature** **Steven Naccarato**

AMENDED INSPECTION SUMMARY

This report has been amended to:
Reflect that Order #001 from inspection 2023-1522-0005 was found to be in compliance with a served date of April 17, 2024.

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Lead Inspector Steven Naccarato (744)	**Additional Inspector(s)** Oraldeen Brown (698) Goldie Acai (741521)
Amended By Steven Naccarato (744)	**Inspector who Amended Digital Signature** Steven C Naccarato Digitally signed by Steven C Naccarato Date: 2024.05.03 15:28:02 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Reflect that Order #001 from inspection 2023-1522-0005 was found to be in compliance with a served date of April 17, 2024.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 18-21, 2024.

The following intake(s) were inspected:

-One intake was related to a missing resident for greater than three hours.
-One intake was related to a medication incident.
-One intake was a follow-up related to responsive behaviours.
-One intake was related to a COVID-19 outbreak.

The following intakes were completed in this inspection: Four intakes were related to a missing resident; and one intake was related to a COVID-19 outbreak

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

Medication Management
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours

AMENDED INSPECTION RESULTS

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 (1) 3.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
3. A resident who is missing for three hours or more.

The licensee has failed to ensure that the Director was immediately informed, in as much detail as was possible of a resident who was missing for three hours or more and followed by the required report.

Rationale and Summary

Staff noticed a resident was missing from the home. A report was made by staff to the after-hours action line but was not followed up by a Critical Incident Report until days later.

Failure to ensure that the Director was immediately informed, in as much detail as was possible of a resident who was missing for three or more hours risks delayed follow up.

Sources: Interviews with DOC and BSO lead, record review of the residents progress notes and CI found within LTCHomes.net.
[741521]

WRITTEN NOTIFICATION: Reporting Critical Incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease

as defined in the Health Protection and Promotion Act.

The licensee had failed to ensure that the Director was immediately informed, in as much detail as was possible of a COVID-19 outbreak.

Rationale and Summary
Public Health declared a COVID-19 outbreak at the home; however, the Director was not immediately notified.

The home not reporting the outbreak to the Director immediately was minimal risk.

Sources: A Critical Incident (CI); The home's policy titled "Critical Incident Reporting (CIS)", last revised March 5, 2024; Interview with the Director of Care (DOC) and other staff.

[744]

WRITTEN NOTIFICATION: Administration of drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee has failed to ensure that no drug was used by, or administered to a resident in the home unless the drug had been prescribed to the resident.

Rationale and Summary

An incorrect medication was administered to a resident by a registered staff member which resulted in the resident being transferred to hospital and returning to the home shortly after.

There was a moderate risk of harm when the resident received a medication which was not prescribed for them.

Sources: A critical incident report, a resident's clinical health records, CareRx medication incident report, home's investigation notes, discharge summary, relevant policies, observations, interviews with an RPN, DOC and other relevant staff.
[698]