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 11, 2023
Original Report Issue Date: April 20, 2023
Inspection Number: 2023-1271-0001 (A1)
Inspection Type: Critical Incident System
Licensee: The Ontario-Finnish Resthome Association
Long Term Care Home and City: Mauno Kaihla Koti,Sault Ste. Marie

Amended By	**Inspector who Amended Digital Signature**
Christopher Amonson (721027)	Christopher E Amonson Digitally signed by Christopher E Amonson Date: 2023.05.23 12:33:55 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
This licensee inspection report has been revised to reflect changes in the summary of NC #002. The inspection 2023-1271-0001 was completed on March 27 - 30, 2023.

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 (A1)

Amended Report Issue Date: May 11, 2023	
Original Report Issue Date: April 20, 2023	
Inspection Number: 2023-1271-0001 (A1)	
Inspection Type: Critical Incident System	
Licensee: The Ontario-Finnish Resthome Association	
Long Term Care Home and City: Mauno Kaihla Koti, Sault Ste. Marie	
Lead Inspector Christopher Amonson (721027)	**Additional Inspector(s)**
Amended By Christopher Amonson (721027)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to:
This licensee inspection report has been revised to reflect changes in the summary of NC #002. The inspection 2023-1271-0001 was completed on March 27 - 30, 2023.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 27 - 30, 2023

The following intake(s) were inspected:
- One intake related to incorrect administration of a medication; and
- One intake related to an allegation of resident neglect.

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Administration of Drugs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 131 (2)

The licensee failed to ensure that a drug was administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary
A medication incident occurred resulting in a resident receiving the wrong type of medication. The staff who administered the medication reported the incident immediately after determining the wrong medication was given. The resident was monitored and required intervention by registered staff. Staff confirmed that safety checks were required prior to administering medications which were not done correctly at the time of the incident.

Sources: Resident health care records; LTC home's investigation file; LTC home's policy titled "Medication Administration: 0704-01" (revised March 2022); interviews with EDOC and staff. [721027]

(A1)
The following non-compliance(s) has been amended: NC #002

WRITTEN NOTIFICATION: Duty to Protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee had failed to ensure that a resident was not neglected by staff.

Section 7 of the Ontario Regulation 246/22 defines neglect as “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.”

Rationale and Summary
A resident was found in their room after having an unwitnessed fall. The resident was noted to have injuries and required personal care.

Staff acknowledged that they were to check on residents at the start and end of their shift in addition to wellness checks throughout their shift. Staff had failed to do the required visual wellness checks on the resident according to the home's policies.

Sources: Resident health records; LTC home's investigation file; LTC home's policy titled "Personal Support Worker, Night Routine: 0207-05" (revised Jan 2023); LTC home's policy titled "RPN Team Leader, Day Routine: 0207-07" (revised Jan 2023); interviews with Executive Director of Care (EDOC) and staff. [721027]