

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Rapport d'inspection en vertu de
la Loi de 2007 sur les foyers de
soins de longue durée**

**Long-Term Care Operations Division
Long-Term Care Inspections Branch**

**Division des opérations relatives aux
soins de longue durée
Inspection de soins de longue durée**

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de
Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 20, 2021	2021_829757_0013	000934-21	Critical Incident System

Licensee/Titulaire de permis

Sioux Lookout Meno-Ya-Win Health Centre
1 Meno-Ya-Win Way P.O. Box 909 Sioux Lookout ON P8T 1B4

Long-Term Care Home/Foyer de soins de longue durée

William A. "Bill" George Extended Care Facility
75 Fifth Avenue Sioux Lookout ON P8T 1K9

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

DAVID SCHAEFER (757)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 10-14 & 17, 2021.

The following intake was inspected during this Critical Incident System (CIS) inspection:

-an intake related to a medication administration error which resulted in an adverse effect to a resident.

This CIS inspection was conducted concurrently with complaint inspection #2021_829757_0012.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator/Team Lead, and a Registered Practical Nurse (RPN).

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, staff-to-resident interactions, and reviewed relevant resident health care records, the home's investigation records, as well as specific licensee policies, procedures, and programs.

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

During the course of this inspection, Non-Compliances were issued.

1 WN(s)

1 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (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. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was administered to a resident unless the drug had been prescribed for the resident.

A Registered Practical Nurse (RPN) administered a medication to a resident, which was intended for another resident, and which had not been prescribed for the resident who received it. The RPN admitted that on that day, they had pre-poured medications for two residents, including the resident who received the medication, despite this practice not being permitted in the home. The RPN indicated that they then inadvertently handed the incorrect medication cup to the resident, who then took the medication. As a result of the incident, the resident experienced an adverse effect.

Sources: A resident's progress notes; a Critical Incident System (CIS) report; the home's safety report related to the incident; and an interview with an RPN. [s. 131. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

Issued on this 9th day of June, 2021

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.