Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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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
Jun 9, 2021	2021_638542_0010	001543-21, 005746-21	Critical Incident System

Licensee/Titulaire de permis

The Ontario-Finnish Resthome Association
725 North Street Sault Ste. Marie ON P6B 5Z3

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

Mauno Kaihla Koti
723 North Street Sault Ste. Marie ON P6B 6G8

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

JENNIFER LAURICELLA (542)

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 14, 17, 18 and 19, 2021.

The following intakes were inspected;

One Intake, related to a medication incident and

One intake, related to a fall with an injury.

During the course of the inspection, the inspector(s) spoke with the Executive Director of Care (EDOC), the Medical Director (MD), Registered Nurse Supervisors (RN), Environmental Supervisor, Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Infection Prevention and Control lead and residents.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions and resident to resident interactions, reviewed relevant health care records, internal investigation notes as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
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	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

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

It was documented that a resident's health status was deteriorating prior to the medication error. The Medical Director (MD) had arrived at the home to conduct an assessment, which resulted in new medication orders and an order to transfer the resident to the hospital for further assessment. The MD had written orders to administer two specific medications by mouth, one time only. A RPN administered the incorrect dosage and route of the medications.

Based on the amount of medication that the resident received there was risk of harm to the resident's health.

During an interview with the EDOC and the MD, both indicated that the RPN made the medication error when they administered the two medications.

Sources: CI report submitted to the Director, a resident's prescribed orders, the home's investigation documentation, interviews with the EDOC and the MD. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 10th day of June, 2021

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

Original report signed by the inspector.