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
Mar 2, 2022	2022_864627_0002	002359-22	Proactive Compliance Inspection

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

SYLVIE BYRNES (627), LOVIRIZA CALUZA (687)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Proactive Compliance Inspection.

This inspection was conducted on the following date(s): February 14-18, 23-25, 2022. Additional off-site activities were completed on February 22, 2022.

During the course of the inspection, the inspector(s) spoke with the Administrator, Executive Director of Care (EDOC), Assistant Director of Care (ADOC), Facility Manager, Resident Assessment Instrument (RAI) Coordinator, Medication Lead, Chair of Family Council, Chair of the Resident Council, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides (DAs), Activity Aides (AAs), Environmental Service Workers, families and residents.

The Inspectors conducted daily observations of the provision of care to the residents, staff to resident interactions, observed infection prevention and control (IPAC) practices, reviewed relevant health care records, relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
2 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any policy required under the act or this regulation, was in compliance with and was implemented in accordance with all applicable requirements under the act.

O. Reg. 79/10, section (s.) 114 (3) a, required the licensee to ensure that written policies and protocols were developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Specifically, the home's policy titled "Medication & Treatment Incidents & Narcotic/Controlled Medication Incident", indicated that any medication incident that involved missing or unaccounted controlled substances would be reported to the Ministry of Health (MOH) immediately. The Royal Canadian Mounted Police (RCMP) would be notified if advised to do so by MOH and to write down any direction whether or not to call the RCMP".

Health Canada's "Guidance on Reporting Loss or Theft of Controlled Substances and Precursors: Timeframes for Reporting", indicated that all losses involving controlled substances or precursors must be reported regardless of the amount and that the incident would be reported to the police based on best practice". There were two incidents of missing controlled drug substances reported by registered staff in 2021. Those incidents were not reported to a police force.

The Medication Lead stated that if a controlled substance was reported missing from the home, an internal investigation and a Critical incident system (CIS) report would be initiated and that they never called the police unless directed by the Ministry of Long-Term Care (MLTC).

It was identified that the home's policy did not align with the prevailing best practice set by Health Canada for reporting the loss of a controlled substance and caused minimal risk to the residents.

Sources: Review of Medication Incidents, review of the home's policy titled "Medication & Treatment Incidents & Narcotic/Controlled Medication Incident" review of Health Canada under the Guidance on Reporting Loss or Theft of Controlled Substances and Precursors: Timeframes for Reporting, and interviews with the Pharmacist, Medication Lead and the EDOC. [#687] [s. 8. (1) (a)]

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 where the act or this regulation requires the licensee of a long term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is in compliance with and is implemented in accordance with all applicable requirements under the act, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff collaborated with each other in the development and implementation of a resident's plan of care, so that different aspects of care were integrated, consistent and complemented each other.

A resident had a medical consultation whereby they were prescribed a medication. The consultation notes and order were given to a unit clerk; however, the unit clerk did not hand the consultation notes and order to the registered staff for processing. Instead, the consultation notes and order were left on the desk of another unit clerk. The consolation notes and the order were found and processed four days later.

The Medication Lead acknowledged that the resident had a medical consult and had returned with a prescription; however, the unit clerk had not given the consultation notes and order to the registered staff for processing. Instead, they had left them on the desk of the other unit clerk and were found four days later.

The lack of collaboration between staff members caused actual risk to the resident as they were started on the medication four days after it was prescribed.

Sources: Resident observations, review of medication incidents, review of the internal investigation notes and resident's health care records, the home's policy titled "Care Plans, Resident Care", interview with the Medication Lead and other staff members. [s. 6. (4) (b)]

Issued on this 3rd day of March, 2022

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

Original report signed by the inspector.