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
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Original Public Report

Report Issue Date: July 9, 2024	
Inspection Number: 2024-1271-0001	
Inspection Type: Critical Incident	
Licensee: The Ontario-Finnish Resthome Association	
Long Term Care Home and City: Mauno Kaihla Koti, Sault Ste. Marie	
Lead Inspector Steven Naccarato (744)	**Inspector Digital Signature**
Additional Inspector(s) Lisa Moore (613)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 10-13, 2024

The following intake(s) were inspected:

- Two intakes were related to resident neglect.
- Two intakes were related to outbreaks.
- One intake was related to resident to resident physical abuse.

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was not neglected by a Personal Support Worker (PSW).

Rationale and Summary
A resident had not been provided care.

A PSW did not provide care to the resident nor complete documentation during their shift. The neglect of the resident was substantiated.

There was no impact to the resident as a result of the PSW's failure to provide the required care interventions. There was a potential low risk for the resident to experience discomfort and altered skin integrity related to the specific care interventions not being provided.

Sources: Critical Incident report; A resident's health records; Investigation file; Policy titled "Personal Support Worker, Evening Routine" (0207-04) last revised January 2024; Personnel Letter; Interviews with Assistant Director of Care (ADOC) and other staff. [613].

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was not neglected by two Personal Support Workers (PSW).

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 not provided care during two shifts.

Two PSWs had not provided proper care for an extended period of time during two separate shifts nor did they accurately document the care of the resident. The neglect of the resident was substantiated.

There was impact to the resident and potential risk to their skin integrity when staff failed to ensure they implemented the required care interventions.

Sources: A Critical Incident (CI) Report; A resident's health records; Investigation file; Policy titled "Personal Support Worker, Day Routine" (0207-02) last revised Jan 2024; Personnel Letters; Interviews with Executive Director of Care (EDOC) and other staff. [613].

WRITTEN NOTIFICATION: Reporting and Complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to immediately report the neglect of a resident to the Director.

Rationale and Summary
A resident was not provided care during two shifts.

The Executive Director of Care (EDOC) verified that a Registered Nurse (RN) had not immediately reported the neglect of the resident to the Director.

There was no impact or risk to the resident when the neglect was not immediately reported to the Director.

Sources: A Critical Incident (CI) Report; A resident's health records; Investigation file; Policy titled "Abuse of Residents, Preventing, Reporting & Eliminating — Schedule D" (0301-1, 0901-1) last revised January 2024; and Interviews with Executive Director of Care (EDOC). [613].