Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Sudbury Service Area Office
159 Cedar Street, Suite 403
Sudbury ON P3E 6A5
Telephone: 1-800-663-6965
SudburySAO.moh@ontario.ca

Original Public Report

Report Issue Date July 20, 2022
Inspection Number 2022_1467_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
St. Joseph's Health Centre of Sudbury

Long-Term Care Home and City
St. Gabriel's Villa of Sudbury, Chelmsford

Lead Inspector
Shelley Murphy #684

Additional Inspector(s)
Amy Geauvreau #642

Inspector Digital Signature
Shelley Murphy
Digitally signed by Shelley Murphy
Date: 2022.07.21 13:12:28 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 4-8, 2022.

The following intake(s) were inspected:

- One intake related to missing controlled substances,
- One intake related to resident nutrition and weight loss,
- Four intakes related to alleged resident-to-resident sexual abuse.

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

- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Sudbury Service Area Office
159 Cedar Street, Suite 403
Sudbury ON P3E 6A5
Telephone: 1-800-663-6965
SudburySAO.moh@ontario.ca

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 131(2)

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

Rationale and Summary

A resident had a physician order for a specified medication.

The resident's progress notes indicated that a medication incident report was completed, and both the family and management were made aware.

A Medication Incident- Final Report, showed that the medication administered to a resident was the incorrect dose.

As per ADOC the entries noted in the eMAR and progress notes were related to the medication administration error.

Sources: CI report, Policy "The Medication Pass section 3-6, last revised 4/21, Progress notes and eMAR for a resident, Medication Incident- Final Report; and ADOC interview.

[#684]