Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 2, 2015	2015_391603_0010 (A1)	S-000776-15, S-000677-15, S-000695-15, S-000694-15, S-000678-15, S-000686-15	Critical Incident System

Licensee/Titulaire de permis

FINLANDIA NURSING HOME LIMITED
c/o Sudbury Finnish Rest Home 233 Fourth Avenue SUDBURY ON P3B 4C3

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

FINLANDIA HOIVAKOTI NURSING HOME LIMITED
233 FOURTH AVENUE SUDBURY ON P3B 4C3

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

SYLVIE LAVICTOIRE (603) GAIL PEPLINSKIE (154)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 23-26, 2015

During the course of the inspection, the inspector directly observed the delivery of care and services to residents, conducted tour of all resident home areas, reviewed resident health care records, reviewed various home policies and procedures, reviewed staff education attendance records, reviewed various home investigation reports, and reviewed critical incident reports sent to the Ministry of Health and Long-Term Care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Chief Clinical Officer, Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, and Residents.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

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	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written policy that promotes zero

tolerance of abuse and neglect of residents and that it is complied with.

Inspector #603 reviewed a Critical Incident Report which indicated that a critical incident regarding staff to resident abuse happened in 2015 and the Critical Incident Report was not filed to the Director until two days after the abuse occurred.

On March 23, 2015, Inspector #603 interviewed #S-102 who explained that the critical incident happened in 2015, but the two witnesses, #S-105 and #S-106 never reported the incident to the home until two after they witnessed the abuse.

The home's investigation report indicated that in 2015, #S-105 was interviewed and could not explain why they had not reported earlier. Staff #106 was also interviewed in 2015, and could not explain why they had not reported earlier. Both #S-105 and #S-106 had previously received training on Resident Abuse and Neglect-Zero Tolerance (ID-20) and Mandatory Reporting to MOHLTC (ID-23) policies. [s. 20. (1)]

2. The licensee has failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

Inspector #603 reviewed a Critical Incident Report which indicated that a critical incident regarding staff to resident abuse that happened in 2015 and the Critical Incident Report was submitted to the Director two days after the abuse occurred.

On March 23, 2015, Inspector #603 interviewed #S-102 who explained that the critical incident happened in 2015, but #S-109 never reported the incident until the day after the abuse occurred, to #S-110 and then reported to the home on that same day. Staff #102 explained that #S-109 did not report these findings earlier because of fear of retaliation by #S-108. Both #S-109 and #S-110 had previously received training on Resident Abuse and Neglect-Zero Tolerance (ID-20) and Mandatory Reporting to MOHLTC (ID-23) policies. [s. 20. (1)]

3. The licensee has failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

Inspector #603 reviewed a Critical Incident Report which indicated that a critical incident regarding staff to resident abuse that happened in 2015 and the Critical Incident Report was submitted to the Director three days after the abuse occurred.

On March 23, 2015, Inspector #603 interviewed #S-102 who explained that the critical incident happened in 2015, but witness #S-111 never reported the incident to the home until 2 days after the abuse occurred.

Inspector #603 reviewed the home's investigation report which indicated that #S-111 was interviewed and could not explain why they had not reported earlier. Both #S-111 and #S-112 had previously received training on Resident Abuse and Neglect-Zero Tolerance (ID-20) and Mandatory Reporting to MOHLTC (ID-23) policies. [s. 20. (1)]

4. The licensee has failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

Inspector #603 reviewed a Critical Incident Report which indicated that a critical incident regarding staff to resident abuse that happened in 2015 and the Critical Incident Report was submitted to the Director three days after the abuse occurred.

On March 23, 2015, Inspector #603 interviewed #S-102 who explained that the critical incident happened in 2015, but witness #S-111 never reported the incident until two days after the abuse occurred.

Inspector #603 reviewed the home's investigation report dated 2015, which indicated that #S-102 interviewed #S-111 regarding a previous written report filed in 2015. The report did not indicate the reasons for reporting the critical incident to the home, two days after the abuse occurred. Staff #111 had previously received training on the home's Resident Abuse and Neglect-Zero Tolerance (ID-20) and Mandatory Reporting to MOHLTC (ID-23) policies. [s. 20. (1)]

5. The licensee has failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

Inspector #603 reviewed a Critical Incident Report which indicated that a critical incident regarding staff to resident abuse that happened in 2015 and the Critical Incident Report was submitted to the Director three days after the abuse occurred.

On March 23, 2015, Inspector #603 interviewed #S-102 who explained that the critical incident happened in 2015 but the 2 witnesses, #S-109 and #S-111 never reported the incident until two days after the abuse occurred.

Inspector #603 reviewed the home's investigation report which indicated that in 2015, #S-109 and #S-111 were interviewed by #S-102 and did not report these findings earlier because of fear of retaliation by #S-108. Staff #109 and #S-111 had previously received training on the home's Resident Abuse and Neglect-Zero Tolerance (ID-20) and Mandatory Reporting to MOHLTC (ID-23) policies. [s. 20. (1)]

6. The licensee has failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

Inspector #603 reviewed a Critical Incident Report which indicated that a critical incident happened in 2015 and the Critical Incident Report was submitted to the Director two days after the abuse occurred.

On March 23, 2015, Inspector #603 interviewed #S-102 who explained that the critical incident happened in 2015, but the witness, #S-109 never reported the incident until two days after the abuse occurred.

Inspector #603 reviewed the home's investigation report which indicated that in 2015, #S-102 interviewed #S-109 and did not report these findings earlier because of fear of retaliation by #S-108.

Inspector #603 reviewed the home's policy, Resident Abuse and Neglect-Zero Tolerance (ID-20) which indicated that any person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm of the resident is to immediately report the suspicion and the information upon which it is based to the Director.

Inspector #603 also reviewed the home's policy, Mandatory Reporting to MOHLTC (ID-23) which indicated that the Charge RN (in the absence of the DOC/CCO) is responsible for reporting abuse of a resident by anyone that resulted in harm or a risk of harm to the resident. This report is to be filed immediately upon becoming aware of the incident. Staff #109 had previously received training on the home's Resident Abuse and Neglect-Zero Tolerance (ID-20) and Mandatory Reporting to MOHLTC (ID-23) policies. [s. 20. (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 there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

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Issued on this 9th day of April, 2015
Issued on this 23rd day of June, 2015 (A1)

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

Original report signed by the inspector.