Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
March 21, 22, 28, 29, 2011 Exit March 31, 2011	2011_154_2829_18Mar104654	Complaint Log S-00660

Licensee/Titulaire
Finlandia Nursing Home Limited, c/o Sudbury Finnish Rest Home, 233 Fourth Avenue, Sudbury, ON P3B 4C3
Fax: 705-524-5723

Long-Term Care Home/Foyer de soins de longue durée
Finlandia Nursing Home Limited, 233 Fourth Avenue, Sudbury, ON P3B 4C3
Fax: 705-524-5723

Name of Inspector(s)/Nom de l'inspecteur(s)
Gail Peplinskie #154

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Complaint Inspection related to resident care.

During the course of the inspection, the inspector spoke with:
-Administrator
-Director of Care
-Assistant Director of Care
-RAI MDS Coordinator
-Registered Nursing Staff
-Personal Support Workers (PSW)

During the course of the inspection, the inspector :
-Reviewed health care record of a resident
-Observed continence care provided to a resident
-Walked throughout all four resident home areas
-Reviewed the home's Continence/Incontinence Care Management Program
-Reviewed RAI MDS information for a resident
-Checked supplies of continence products in a resident's room and medication room within resident's home area
-Reviewed the list of residents using "pull-up products" other than provided by the home

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

6 WN
3 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, S.O. 2007. c.8, s. 3(1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

Findings:
1. The Licensee did not ensure that a resident's right to be afforded privacy in treatment and in caring for personal needs was fully respected and promoted. On March 28, 2011 at 10:40 a.m. Inspector #154 observed a resident being bathed in a tubroom with the door open & privacy curtain pulled. Inspector could see the resident's silhouette past the curtain when lifted out of the tub with the lift. Acoustic privacy was not provided to the resident when caring for personal needs.

Inspector ID #:	154

WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 6(1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident.

Findings:
1. March 28, 2011, Inspector #154 reviewed the plan of care for a resident. The plan of care for the resident does not provide clear directions, related to continence care, to staff and others who provide direct care.

Inspector ID #:	154

WN #3: The Licensee has failed to comply with O. Reg 79/10, s.110(1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:

1. Staff apply the physical device in accordance with any manufacturer's instructions.

Findings:
1. The Licensee did not ensure that all requirements are met with respect to restraining of a resident. On March 29, 2011 at 08:30 a.m. Inspector #154 observed a resident in the bedroom in a wheelchair with lap belt applied loosely with belt sitting in the resident's lap. The physical device was not applied according to manufacturer's directions.

Inspector ID #:	154

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 with O. Reg 79/10, s.110(1)1 in respect of Finding #1, to be implemented voluntarily.

WN #4: : The Licensee has failed to comply with O. Reg 79/10, s.17(1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that, (a) can be easily seen, accessed and used by residents, staff and visitors at all times.

Findings:

1. March 29, 2011 @ 08:47 a.m. Inspector #154 observed a resident in the bedroom, sleeping in bed with call bell cord hanging behind headboard. The plan of care for the resident indicates to ensure call bell is within easy reach. The Licensee did not ensure that the communication and response system in the resident's room could be easily seen and accessed.
2. March 28, 2011 @ 08:20 a.m. Inspector #154 observed a resident in the bedroom, in bed with call bell hanging at the head of the bed against the wall. The plan of care for the resident indicates to ensure call bell is within easy reach. The Licensee did not ensure that the communication and response system in the resident's room could be easily seen and accessed.
3. March 28, 2011 @ 10:57 a.m. Inspector #154 observed a resident in bed with call bell hanging at the head of the bed. The plan of care for the resident indicates to ensure call bell is within easy reach. The Licensee did not ensure that the communication and response system in the resident's room could be easily seen and accessed.

Inspector ID #:	154

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 with O. Reg 79/10, s. 17(1)(a) in respect of Findings #1-3, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O. Reg 79/10, s. 87(2) as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces.

Findings:

1. March 29, 2011 @ 08:40 a.m. Inspector #154 observed a yellow lounge chair in Manty unit lounge with the seat soiled
2. March 28/11 @ 08:20 a.m. Inspector #154 observed in Manty unit, 2 blue lounge chairs with the seats and armrests soiled.
3. March 28/11 @ 08:20 a.m. Inspector #154 observed in hall alcove on Manty unit, I yellow chair with seat soiled.

Inspector ID #:	154

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 with O. Reg 79/10, s. 87(2)(a)(ii) in respect of Finding #1-3, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O. Reg 79/10, s. 87(2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for, (b) cleaning and disinfection of resident care equipment, such as whirlpools, tubs, shower chairs, and lift chairs and supplies and devices, including personal assistance services devices, assistive aids, and positioning aids and contact surfaces, using hospital grade disinfectant and in accordance with manufacturer's specifications
Findings: 1. March 29, 2011 @ 08:35 a.m. Inspector #154 observed a resident in their bedroom sitting in a wheelchair, wheelchair soiled, lap belt which was applied to resident was soiled.

Inspector ID #:	154

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** May 12/11