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_18Mar105015	Complaint Log S-00752

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 two residents
-walked throughout all four resident home areas
-reviewed the home's Continence/Incontinence Care Management Program
-reviewed the home's Policy and Procedure for Restraint Use
-reviewed RAI MDS information for two residents
-checked supplies of continence products in a resident's room and medication room within resident's home area

The following Inspection Protocols were used during this inspection:
Responsive Behaviours
Safe and Secure Home
Continence Care and Bowel Management
Accommodation Services/Housekeeping

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

5 WN
2 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. 15(2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary.

Findings:

1. March 21/11, Inspector #154 observed the following in Haapa dining room;
   - one corner of Haapa dining room, soiled, where the floor moulding and floor surface meet
   - the wall and floor mouldings under the servery counter soiled
   - many areas of dining room where floor moulding meets floor surface were soiled
   - some dining room chairs soiled (i.e red chair seat, green print chair back & seat soiled)
   - inside servery, some lower walls soiled and floor heavily soiled around edges of room, around equipment and under equipment

2. March 21/11 @ 13:15 Inspector 154 observed 1 brown food cart worn and soiled and 1 blue food cart worn and soiled in the servery in Haapa unit.

3. March 21, 2011 in Haapa TV lounge, Inspector #154 observed 1 orange striped chair with seat soiled and 1 blue cloth lounge chair with seat and both armrests soiled. Inspector #154 observed soiled areas behind lounge chairs where floor surface and mouldings meet.

4. March 22, 2011 Inspector #154 observed a wheelchair owned by Finlandia and loaned to a resident, to be soiled on the seat, footrest & armrests.

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 LTCHA, S.O. 2007. c.8, s. 15(2)(a) in respect of findings #1-4 to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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:

1 Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Findings:

1. On March 21/11 @ 13:40 p.m. Inspector #154 observed a resident in their room in bed, sleeping, with both bedrails up on the bed, lying on top of blankets with incontinent pad under the resident. The resident had glasses on, slippers on and no blanket covering them.

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. At the request of Inspector #154, the Director of Care obtained and provided a copy of the Manufacturer's Instructions that indicated that "a seatbelt is properly applied when the seatbelt is secured across the resident's hips firmly (so you can fit only two fingers between the seatbelt and the resident's body) and the resident's pelvis is maintained in the seat while you secure the seatbelt".
2. On March 21, 2011 and March 22, 2011 Inspector 154 observed a resident in a wheelchair with seatbelt restraint not applied in accordance with manufacturer's instructions. The physical device was applied low, loose and sitting in the resident's lap.
3. On March 21, 2011 and March 22, 2011 Inspector #154 observed a resident in a wheelchair with seatbelt restraint not applied in accordance with manufacturer's instructions. The physical device was applied low, loose and sitting in the resident's lap.
4. On March 22, 2011 Inspector #154 observed a resident in a wheelchair with seatbelt restraint not applied in accordance with manufacturer's instructions. The physical device was applied very loosely & sitting in the resident's lap.

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 #2-4, to be implemented voluntarily.

WN #4: 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. On March 22, 2011 Inspector #154 observed a resident's wheelchair to be soiled on the seat, footrest and seatbelt.

2. On March 22, 2011 Inspector #154 observed a resident's wheelchair to be soiled on the seat, wheels and seatbelt.
3. On March 21, 2011 Inspector #154 observed a resident's wheelchair to be soiled on the seat and footrest.

Inspector ID #:	154

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,
(d) addressing incidents of lingering offensive odours.

Findings:

1. On March 22, 2011 at 08:50 a.m. Inspector #154 detected a lingering urine odour in the bathroom of a resident's room.
2. On March 22, 2011 at 08:50 a.m. Inspector #154 detected a lingering urine odour in the bathroom and bedroom of a resident's room.
3. On March 22, 2011 at 11:50 a.m. Inspector #154 detected a lingering urine odour in a resident's room.
4. On March 22, 2011 at 11:52 a.m. Inspector #154 detected a lingering urine odour in a resident's room.

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 13/11