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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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
Feb 22, 2017	2016_572627_0030	021279-16, 021283-16, 021285-16	Follow up

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 BYRNES (627), SYLVIE LAVICTOIRE (603)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): December 5-9, 2016.

This Follow up Inspection is related to the following compliance orders (CO) issued to the home:
CO #001 related to plan of care;
CO #002 related to zero tolerance of abuse/neglect policy;
CO #003 related to the home's duty to protect residents from abuse and neglect.

A Critical Incident System (CI) inspection #2016_572627_0028, and and a Complaint inspection, #2016__572627_0029, were conducted concurrently.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and their families.

The Inspector(s) conducted a daily walk through resident areas, observed the provision of care towards residents, observed staff to resident interactions and resident to resident interactions, reviewed residents' health care records, staff training records, staffing schedules, policies and procedures.

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.
- **2 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 20. (2)	CO #002	2016_428628_0003	603

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

CO #001 was issued during inspection #2016_428628_0003 (A1).
The compliance order required the licensee to:
a) Perform an audit of all resident care plans to ensure that the care each resident required was clearly outlined in the plan of care.
b) Develop and implement a process to audit compliance with ensuring that care was provided as specified in the plan.
c) Maintain a record of the audit, when it was completed, who completed it and what the results were. The home was to maintain a record of what changes were made as a result of the audit and when these changes occurred.
d) Provide training to all staff involved in the direct care of residents. The training was to include but not be limited to: the importance of providing the care as was specified in the plan and potential consequences to residents if not provided as specified in the plan.
d) Maintain a record of the required training of all staff involved in the care of residents, who completed the training, what the training entailed and when the training had been completed.

Although the licensee met the requirements as ordered, further Non-Compliance was identified during this inspection.

Inspector #627 reviewed a Critical Incident (CI) report that was submitted to Director, which alleged resident to resident sexual abuse between resident #003 and #002.

A review by the Inspector of the current Kardex for resident #003, in effect at the time of the inspection, revealed a specific intervention when the resident was in their room.

On a certain date, the Inspector observed that resident #003 was in bed and the specific intervention was not followed.

At a later date, the Inspector observed resident #003 in bed sleeping and the specific intervention was not followed. The Inspector approached the staff members who were in report at the time and inquired if resident #003's should have had the specific intervention while in their room. PSW #109 confirmed that the specific intervention should have been followed and proceeded to apply the intervention.

On another date, the Inspector walked by resident #003's room and observed that the resident was asleep in their bed. The specific intervention had not been followed.

On another date, the Inspector walked by resident #003's room and observed resident #003 sleeping in bed. The specific intervention had not been followed. The Inspector approached RPN #103 who confirmed that the specific intervention should have been followed and proceeded to apply the intervention. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

CO #003 was issued during inspection 2016_428628_0003 (A1).

The compliance order required the licensee to:
Ensure that resident #004 and all other residents are protected from abuse by anyone.
Achieving compliance shall include, but not be limited to:
1-Develop a system to ensure the home's internal investigations related to every alleged, suspected or witnessed incident of abuse of a resident by anyone, was immediately and

thoroughly investigated,
2-Developing and implementing a system to ensure that any allegation of abuse or neglect was reported to the Director immediately,
3-Reviewing and revising the policy to ensure it clearly sets out what constitutes abuse and neglect and that promoted zero tolerance of abuse and neglect of residents.

Although the licensee met the requirements as ordered, further Non-Compliance was identified during this inspection.

The Long-Term Care Homes Act, (LTCHA) 2007, defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Inspector #603 reviewed a Critical Incident (CI) report which was submitted to the Director. The CI report indicated that RPN #104 heard a resident yelling. The RPN entered resident #005's room and a physical altercation between resident #006 and #005.

A)The CI occurred on a specific date and time; the CI report was submitted to the Director 12 hours 49 minutes later. According to the Long-Term Care Homes Act, 2007 s.24 (1) a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director. Please refer to written notification (WN) #1 in CIS inspection #2016_572627_0028 for further details.

B) Inspector #603 reviewed resident #006's health care records and interviewed staff who reported that resident #006 was not reassessed for responsive behaviours. According to the LTCHA, O. Reg. 79/10 s. 53. (4), the licensee shall ensure that, for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. Please refer to written notification (WN) #3 in CIS inspection #2016_572627_0028 for further details.

C) A review by the Inspector, of resident #006's plan of care revealed that the resident's care plan had been reviewed and updated on a specific date,one year prior to the incident, for the focus of exhibiting responsive behavoiurs, as a result of Behavioural Support Ontario's (BSO) assessment and recommendations completed on a specific date.

A review of prior incidents (incidents prior the CI report submitted to the Director), documented in resident #006's progress notes, indicated a progression and escalation in resident #006's responsive behaviour: On a specific date, resident #006 exhibited responsive behaviours toward another resident; at a later date, resident #006 was seen exhibiting responsive behaviours towards another resident. With each incident, the residents were separated and redirected. No further assessments, or interventions were implemented, nor was BSO involved.

During the same review, the Inspector noted that resident #006 had a history of responsive behaviours, prior to the CI being submitted. Please refer to written notification (WN) #3 in CIS inspection #2016_572627_0028 for further details. No further assessments or interventions were implemented after the previous incidents.

During an interview with the Inspector, the Assistant Director of Care (ADOC) revealed that there were no further interventions implemented. They explained that the staff simply continued to follow the BSO recommendations that had been implemented one year prior to all the responsive behaviour incidents..

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 24th day of February, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SYLVIE BYRNES (627), SYLVIE LAVICTOIRE (603)
Inspection No. / No de l'inspection :	2016_572627_0030
Log No. / Registre no:	021279-16, 021283-16, 021285-16
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Feb 22, 2017
Licensee / Titulaire de permis :	FINLANDIA NURSING HOME LIMITED c/o Sudbury Finnish Rest Home, 233 Fourth Avenue, SUDBURY, ON, P3B-4C3
LTC Home / Foyer de SLD :	FINLANDIA HOIVAKOTI NURSING HOME LIMITED 233 FOURTH AVENUE, SUDBURY, ON, P3B-4C3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Angela Harvey

To FINLANDIA NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2016_428628_0003, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall develop and implement a process to ensure that the care set out in the plan of care for resident #003, is provided to the resident as specified in the plan.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

CO #001 was issued during inspection #2016_428628_0003 (A1).
The compliance order required the licensee to:
a) Perform an audit of all resident care plans to ensure that the care each resident required was clearly outlined in the plan of care.
b) Develop and implement a process to audit compliance with ensuring that care was provided as specified in the plan.
c) Maintain a record of the audit, when it was completed, who completed it and what the results were. The home was to maintain a record of what changes were made as a result of the audit and when these changes occurred.
d) Provide training to all staff involved in the direct care of residents. The training was to include but not be limited to: the importance of providing the care as was specified in the plan and potential consequences to residents if not provided as specified in the plan.
d) Maintain a record of the required training of all staff involved in the care of residents, who completed the training, what the training entailed and when the training had been completed.

Although the licensee met the requirements as ordered, further Non-Compliance was identified during this inspection.

Inspector #627 reviewed a Critical Incident (CI) report that was submitted to Director, which alleged resident to resident sexual abuse between resident #003 and #002.

A review by the Inspector of the current Kardex or resident #003, in effect at the time of the inspection revealed a specific intervention when the resident was in their room.

On a certain date, the Inspector observed that resident #003 was in bed and the specific intervention was not followed.

At a later date, the Inspector observed resident #003 in bed sleeping and the specific intervention was not followed. The Inspector approached the staff members who were in report at the time and inquired if resident #003's should have had the specific intervention while in their room. PSW #109 confirmed that the specific intervention should have been followed and proceeded to apply the intervention.

On another date, the Inspector walked by resident #003's room and observed that the resident was asleep in their bed. The specific intervention had not been followed.

On another date, the Inspector walked by resident #003's room and observed resident #003 sleeping in bed. The specific intervention had not been followed. The Inspector approached RPN #103 who confirmed that the specific intervention should have been followed and proceeded to apply the intervention.

The decision to issue this compliance order was based on the scope which was determined to be a isolated, the severity was determined to be potential for actual harm. Despite Ministry of Health action, a compliance order (CO) issued during inspection #2016_428628_0003 and a voluntary plan of correction (VPC) issued during inspection #2015_332575_0007, non-compliance continues with original area of non-compliance. (627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2017

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2016_428628_0003, CO #003;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Order / Ordre :

The licensee shall prepare, submit, and implement a plan for ensuring that resident #005 and every other resident in the home, is protected from abuse, from resident #006.

This plan shall be submitted in writing to Sylvie Byrnes, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564 3133 or email SudburySAO.moh@ontario.ca. This plan must be submitted by March 2 ,2017.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

CO #003 was issued during inspection 2016_428628_0003 (A1).

The compliance order required the licensee to:
Ensure that resident #004 and all other residents are protected from abuse by anyone. Achieving compliance shall include, but not be limited to:
1-Develop a system to ensure the home's internal investigations related to every alleged, suspected or witnessed incident of abuse of a resident by anyone, was immediately and thoroughly investigated,
2-Developing and implementing a system to ensure that any allegation of abuse or neglect was reported to the Director immediately,
3-Reviewing and revising the policy to ensure it clearly sets out what constitutes abuse and neglect and that promoted zero tolerance of abuse and neglect of residents.

Although the licensee met the requirements as ordered, further Non-Compliance was identified during this inspection.

The Long-Term Care Homes Act, (LTCHA)2007, defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Inspector #603 reviewed a Critical Incident (CI) report which was submitted to the Director. The CI report indicated that RPN #104 heard a resident yelling. The RPN entered resident #005's room and observed a physical altercation between resident #006 and #005.

A)The CI occurred on a specific date and time; the CI report was submitted to the Director 12 hours 49 minutes later. According to the Long-Term Care Homes Act, 2007 s.24 (1) a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director. Please refer to written notification (WN) #1 in CIS inspection #2016_572627_0028 for further details.

B) Inspector #603 reviewed resident #006's health care records and interviewed staff who reported that resident #006 was not reassessed for responsive behaviours. According to the LTCHA, O. Reg. 79/10 s. 53. (4), the licensee shall ensure that, for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. Please refer to written notification (WN) #3 in CIS inspection #2016_572627_0028 for further details.

C) A review by the Inspector, of resident#006's plan of care revealed that the resident's care plan had been reviewed and updated on a specific date,one year prior to the incident for the focus of exhibiting responsive behaviours, as a result of Behavioural Support Ontario's (BSO) assessment and recommendations completed on a specific date

A review of prior incidents (incidents prior the CI report submitted to the Director), documented in resident #006's progress notes, indicated a progression and escalation in resident #006's responsive behaviours: On a specific date, resident #006 exhibited responsive behaviours toward another

resident; at a later date, resident #006 was seen exhibiting responsive behaviours towards another resident. With each incident, the residents were separated and redirected. No further assessments, or interventions were implemented, nor was BSO involved.

During the same review, the Inspector noted that resident #006 had a history of responsive behaviours, prior to the CI being submitted. Please refer to written notification (WN) #3 in CIS inspection #2016_572627_0028 for further details. No further assessments or interventions were implemented after the previous incidents.

During an interview with the Inspector, the Assistant Director of Care (ADOC) revealed that there were no further interventions implemented. They explained that the staff simply continued to follow the BSO recommendations that had been implemented one year prior to all the responsive behaviour incidents.

Non-Compliance (NC) related to this finding was also issued under CO #001 and a Voluntary Plan of Correction (VPCs), of the CIS inspection #2016_572627_0028.

The decision to issue this compliance order was based on the scope which was determined to be isolated, the severity was determined to be actual harm. Despite Ministry of Health action, a compliance order (CO) issued during inspection #2016_428628_0003, non-compliance continues with original area of non-compliance. (627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 16, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 22nd day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sylvie Byrnes

Service Area Office /
Bureau régional de services : Sudbury Service Area Office