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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 13, 2017	2017_616542_0007	003914-17	Resident Quality Inspection

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

JENNIFER LAURICELLA (542), ALAIN PLANTE (620), AMY GEAUVREAU (642), MICHELLE BERARDI (679), SARAH CHARETTE (612)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 20-24 and March 27-31, 2017

The following intakes were completed during this inspection:

Three follow up intakes related to plan of care, abuse and reporting to the Director were completed during this inspection;

One complaint log submitted to the Director related to falls and the communication system;

Two critical incident reports, submitted by the home related to falls resulting in a significant change in resident health status and

Four critical incident reports, submitted by the home related to staff to resident abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), the Volunteer Program Coordinator, Director of Life Enrichment, Manager of Maintenance, Food Services Supervisor, Personal Support Workers (PSWs), dietary staff, housekeeping staff, residents and family members.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, employee files and reviewed various licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **6 VPC(s)**
- **3 CO(s)**
- **1 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. 19.	CO #002	2016_572627_0030	612
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #001	2016_572627_0028	612

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.

Compliance Order (CO) #001 was previously issued during inspection #2016_572627_0030, on February 22, 2017, with a compliance date of February 28, 2017.

The compliance order required the licensee to develop and implement a process to ensure that the care set out in the plan of care for resident #003, was provided to the resident as specified in the plan. The grounds of the order identified that resident #003 was to have a wander strip applied across their door.

Inspector #612 noted that resident #003, referred to in the compliance order, had been discharged from the home.

A) Inspector #612 observed resident #010's room on March 22, 2017, and noted that the resident had a wander strip attached to one side of the door way, but was not applied across the door. On March 23, 2017, the Inspector observed that the resident was sitting in their wheelchair in their room and that the wander strip was hanging down the door frame and not applied across the door.

On March 23, 2017, Inspector #612 interviewed resident #010 who stated that there were some residents on the unit who wander into their room, therefore, the staff would apply the wander strip to prevent these residents from entering their room. The resident stated that the wander strip should be applied at all times and confirmed that it was not currently applied across their doorway.

Inspector #612 reviewed the resident's electronic care plan and noted that it stated that

the stop sign wander strip was to be applied to doorway at all times to deter wandering co-residents from entering.

On March 27, 2017, Inspector #612 interviewed PSW #124 who stated that the wander strip should have been applied across resident #010's doorway at all times.

B) On March 24, 2017, Inspector #612 observed on a specific unit at 0914 hours, resident #008 enter the room of another resident. Resident #008 entered the washroom, then went to bed A, then bed B and then exited the room and proceeded down the hallway. Resident #008 returned at 0920 hours and entered the same room again, and then exited and went into the dining room. At 0935 hours, RPN #116 applied the wander strip across the doorway of room that resident #008 entered.

At 0940 hours, resident #008 walked towards the same room and saw the wander strip applied across the door and then turned to enter the dining room. At 1420 hours, the Inspector observed that the wander strip was not across the doorway of the same room and resident #008 continued to wander the unit, and entered the room again.

Inspector #612 reviewed resident #008's printed care plan and noted that it stated that the wander strip was to be in place across co-resident's rooms as resident #008 would often wander into other resident's rooms.

Inspector #612 reviewed resident #021's printed care plan and noted that it stated that the wander strip was to be applied to doorway at all times to deter wandering co-residents from entering.

Inspector #612 reviewed resident #022's printed care plan and noted that there was a hand-written intervention added March 20, 2017, which stated 'wander strip on door'.

C) On March 30, 2017, at 0930 hours, Inspector #612 observed that there was no wander strip applied across the doorway of resident #034's room. At 1130 hours, Inspector #612 again observed that there was no wander strip applied across the doorway. The Inspector observed resident #008 sleeping in resident #034's bed. At 1145 hours, RPN #116 noted that resident #008 was sleeping in resident #034's bed and asked a PSW to remove the resident and apply a wander strip across the doorway.

The Inspector reviewed resident #034's printed care plan and noted the following intervention, wander strip to be applied to doorway at all times to deter wandering co-

residents from entering.

Inspector #612 interviewed PSW #115 on March 24, 2017, who stated that the wander strips should be applied across the doorway of resident's #021 and #022 room and resident #034's room to deter resident #008 from entering those rooms.

On March 31, 2017, Inspector #612 interviewed RPN #116 who stated that the wander strips should be applied across the door ways of resident #021 and #022's room as well as resident #034's room to prevent resident #008 from entering. RPN #116 stated that sometimes a resident may remove a wander strip, therefore staff have to constantly monitor the wander strips and reapply them across the doorways.

On March 30, 2017, Inspector #612 interviewed the Director of Care (DOC) who stated that resident #008 would often wander into other resident's rooms, therefore the wander strips were to be applied across the doorway to prevent resident #008 from entering the rooms. The DOC stated that the wander strips should be applied across the doorway of the rooms as indicated in the care plans.

D) Inspector #620 conducted a review of a Critical Incident (CI) report that was submitted to the Director which indicated that resident #010 had a fall for which the resident was sent to the hospital which resulted in a significant change to the resident's condition. The report specified that the resident was diagnosed and treated for a fracture.

Inspector #620 reviewed the home's investigation related to the resident's fall which indicated that as a result of the fall, the resident's plan of care was altered to include two specific interventions.

Inspector #620 reviewed the resident's care plan that was current at the time of the inspection and identified one of the two interventions. The care plan also advised staff to, "document care being resisted on incidental Point of Care (POC). If resident refuses care, leave and return in 5-10 minutes."

On March 27, 2017, Inspector #620 interviewed resident #010 who indicated that one of the specific interventions was not in use and had not been applied for the last few days. They stated that they were unsure why.

Inspector #620 interviewed PSW #124 who indicated that the resident often refused to

implement one of the specific interventions and that as a result they were not applied for a few days. PSW #124 stated that they did not document the refusal.

Inspector #620 reviewed the home's policy titled, "Falls Prevention and Management" with a last review date of June 14, 2016. The policy advised health care aides and personal support workers to, "follow procedures and care plan for high risk falls admissions" and, "report changes to registered staff." The policy also indicated that the intervention, was to be utilized to reduce fractures.

Inspector #620 interviewed the DOC who confirmed that resident #010's specific intervention had not been applied for, "some time." They indicated that the resident had a history of refusing. They told the inspector that the PSW staff should have documented the refusal in POC and notified registered staff. They said that the PSW staff should have attempted to persuade the resident to utilize the intervention on an ongoing basis, rather than discontinue the use.

E) Inspector #542 conducted a review of a Critical Incident (CI) report that was submitted to the Director for staff to resident abuse. Inspector #542 reviewed the CI report which indicated that resident #004 was found upset and crying and reported to RPN #147 that PSW #145 was rough and screamed at them. Resident #004 had asked PSW #145 to assist them to the bathroom as they were feeling weak, and the PSW refused. This resulted in resident #004 being incontinent, soiling themselves and their shoes. PSW #145 continued to refuse to assist the resident with any care.

Inspector #542 completed a review of the home's investigation regarding the incident. The investigation revealed that PSW #145 did not follow resident #004's care plan with regards to their continence care needs.

Inspector #542 reviewed the care plan that was in place at the time of the incident. It was documented that resident #004 required one to two staff extensive assistance to bring them to the bathroom, adjust clothing, and provide peri-care.

On March 28, 2017, Inspector #542 interviewed the DOC who indicated that PSW #145 did not follow the plan of care for resident #004 during this incident. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: 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 had failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A) Inspector #542 conducted a review of a Critical Incident (CI) report that was submitted to the Director for staff to resident abuse. The CI report indicated that resident #004 was found upset and crying and reported to RPN #147 that PSW #145 was rough and screamed at them. See WN #2, finding three for further details.

Inspector #542 reviewed the progress notes for resident #004. It was documented a day prior to the submission of the CI report, that resident #004 was found upset and crying as PSW #145 yelled at them and was rough.

The home's investigation concluded that PSW #145 was emotionally abusive and neglectful towards resident #004. PSW #145 was terminated from their employment.

Upon review of the home's investigation file, another note for a different incident was located which indicated that resident #004 had stated that PSW #145 did not assist them with care and that they were rough with them.

On March 28, 2017, Inspector #542 and #620 interviewed the DOC. Inspector #542 asked if the home completed an investigation regarding the other allegation. The DOC indicated that the home completed a "reinstruction document" and did not complete further investigation regarding the alleged abuse. The DOC stated that if a resident accused a staff member of being rough, then further investigation should have occurred.

Inspector #542 reviewed the home's policy, titled, "Resident Abuse and Neglect – Zero Tolerance, last revised June 2016. It was documented in the policy that the home promotes a zero tolerance of abuse and neglect of residents by anyone.

B) Inspector #620 reviewed a CI report that was submitted to the Director on a specific day, at a specific time for alleged staff to resident physical abuse. The CI report indicated that resident #011 was found to have bruising to both wrists and hands, bilaterally. The home documented in their report that the incident had occurred five hours earlier on the day of the report being submitted.

A review of the home's investigation file revealed that the home had determined that PSW #105 was responsible for the injury to resident #011 and that the incident had been witnessed by PSW #148 on the evening shift the prior day to the submission of the CI report. In a documented interview conducted by the home, PSW #148 described that they heard PSW #105 speaking loudly to resident #011 in the resident's bathroom.

A review of the home's investigation revealed that on the evening before the submission of the CI report, PSW #148 failed to immediately report their observation of abuse; but rather, PSW #148 described the incident to PSW #149 and indicated that they were going to report it. The next day, RPN #147 discovered the bruising on resident #011 and documented the bruising in Point Click Care. RPN #147 suspected that an incident of abuse had occurred but did not report the suspicion until the end of their working day, when they notified RN #150.

Inspector #620 observed images of the injuries to resident #011's left and right wrist.

Inspector #620 reviewed the home's policy titled, "Resident Abuse and Neglect – Zero Tolerance" with a last reviewed date of June 2016. The policy indicated that any person who suspected that abuse had occurred were required to immediately report their suspicion to the ADOC/DOC or Administrator, and if after-hours, the Manager on-call.

Inspector #620 interviewed the Assistant Director of Care (ADOC) who indicated that the home had determined that PSW #105 had abused resident #011. The ADOC also indicated that PSW #148 and RPN #147 failed to report the abuse immediately as required by the home's policy on zero tolerance of abuse. They indicated that PSW #105 was terminated as a result of the incident and that PSW #148 and RPN #147 were to receive discipline for failure to report. [s. 20. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart, (i) that was used exclusively for drugs and drug-related supplies, (ii) that it was secured and locked and (iv) that complied with manufacturer's instructions for the storage of the drugs.

A) On March 20, 2017, during the initial tour of the home, Inspectors #612 and #642 observed in two different home area tub rooms: one used bottle of a medicated cream on the counter top with a worn out prescription label, as well as, 10 medicated creams in a

basket.

On March 24, 2017, Inspector #612 observed a PSW linen cart outside of a resident's room on a specific unit. The Inspector observed three prescription creams on the cart. The PSW cart was out of site of the PSW. Subsequently, Inspector #679 observed an unattended linen cart in the hallway of the same home unit, outside of a resident's room with one tube of a medicated cream.

A review of the home's policy #84 titled "Administration of Prescription Products by UCP", effective April 2006, identified that PSWs are "to return product to the registered staff after each use for storage in the medication room or locked medication cart".

During an interview with Inspector #679, RN #118 identified that it was the home's expectation that all medicated creams were contained in a basket within the locked medication room.

During an interview with Inspector #678, the ADOC, stated that it was the home's expectation that all medicated creams were locked within the medication room.

B) On March 24, 2017 Inspector #679 observed an unattended and unlocked medication cart in one of the home's dining rooms at 1200 hours. The RPN was noted to be in a resident's room and did not have the cart in their view.

During an interview with Inspector #679, RPN #119 stated that the medication cart was required to be locked when it was not within eyesight of the RPN.

During a subsequent observation on March 24, 2017 at 1220 hours, Inspector #679 observed a medication cart, unlocked and unattended in another dining room for twenty-one minutes and out of sight of the RPN.

During an interview with Inspector #679, RPN #107 stated that the medication cart should have been locked.

Inspector #679 reviewed the electronic medication policy titled: "Medisystem pharmacy: Pharmacy policies and procedure manual for facilities in Ontario: Subject Medication Pass" last revised January 2017, which indicated "Do not leave the medication cart unattended at any time unless all medications are securely locked and resident information is secured on eMar/eTar."

During an interview with the ADOC on March 30, 2017, they identified that it was the home's expectation that the medication carts were locked at all times when unattended.

C) During an observation of the medication cart on March 27, 2017, with RPN #129. Inspector #642 observed a bottle of a certain medication that contained tablets that had expired in February 2017.

A review of the policy titled "Medisystem pharmacy: Pharmacy policies and procedure manual for facilities in Ontario: Pharmacy Section" last revised January, 2017, identified that "the following medications will be identified, destroyed and disposed of including: Expired medications."

RPN #129 identified that the pharmacy does an audit for expired products and confirmed that the expired medications should have been removed from the medication cart. [s. 129. (1) (a)]

2. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in a locked area or stored in a separate locked area within a locked medication cart.

On March 28, 2017, Inspector #679 observed an unlocked refrigerator in a specific medication room. The refrigerator contained a small portable lock box which contained a controlled substance.

During an interview with Inspector #679, RPN #123 identified that the refrigerator was to remain locked.

A review of the homes policy titled "Medisystem pharmacy: Pharmacy policies and procedure manual for facilities in Ontario: Pharmacy section", last revised 2017 identified that "Narcotic and controlled substances must be stored in a double locked container in the medication cart or in the medication room."

During an interview with the ADOC on March 20, 2017, they identified that it was the home's expectation that the refrigerator containing the controlled substance was locked at all times. [s. 129. (1) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

A) On the first day of this inspection (March 22, 2017), Inspector #612 conducted a tour of all home areas. During that tour, maintenance concerns were identified in a specific unit of the home; specifically, there was wall paper missing and/or damaged under the railing for approximately the whole length of the hallway. Maintenance concerns were also observed on the another unit. A window on the same unit appeared to have been leaking at the top of the window's frame. There was drywall missing within the frame and there were plastic pails to capture the water directly below the area of the leak.

The following is a list of observations of disrepair identified in various areas of the home during stage one of the RQI, specifically resident rooms:
- Inspector #679 observed that there was a square of incomplete, unpainted, drywall repair above the toilet in a resident's room,
- an area measuring approximately 60 cm of water damage with cracked and peeling paint in a resident's room, an unpainted, unsanded drywall repair on the wall above bathroom sink with signs of recent water damage in another resident's room,
- Inspector #620 observed a bathroom faucet that was leaking, water damage to wall

under toilet paper dispenser, scuffing on the right side of the wall upon in the entry way of the room, and surface damage around the mirror in the bathroom,
- observed surface cracks that extended down the corner of the wall in a resident's room,
- Inspector #642 observed that there were marks on wall behind lounge chair, flooring with stains, and abrasions on the bathroom sink,
- Inspector #679 observed cracking along right side of the mirror closest to the door, and cracked drywall adjacent to the chair-close to window in a resident's room,
- In room another resident's room, Inspector #679 observed an unsanded, unpainted drywall patch around mirror, a large crack in the ceiling and unpainted surfaces, and chipped paint around the window and,
- Inspector #642 observed that the surface right side of the bathroom counter was worn through to it's substrate in an additional resident's room.

Inspector #620 interviewed the Maintenance Manager who indicated that they were aware that the home was experiencing some ongoing roof leaks. They indicated that the leaking was a result of seasonal weather conditions, and that this year had been particularly difficult. The Maintenance Manager also indicated that the number of unfinished drywall repairs were likely a result of staff making a partial repair but not documenting the repair. As a result, the drywall repairs were not being completed like they should have been.

B) On March 20, 2017, Inspector #612 observed that resident #023's call bell at their bedside would not activate after being pressed by the Inspector.

Inspector #612 reported to RN #118 that resident #023's call bell was not working, and after RN #118 tested it, they confirmed that it was not working and it should have been.

The Inspector reviewed the resident's printed care plan which listed the following intervention under the 'at risk for falls' focus: reinforce need to call for assistance.

On March 30, 2017, the Inspector interviewed the DOC who stated that the call bell should be functioning at all times for the residents. If it was not functioning, the call bell should be replaced. [s. 15. (2) (c)]

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 the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's resident-staff communication response system was easily seen, accessed and used by residents, staff and visitors at all times.

Inspector #612 observed on two days, March 20, 2017 and March 21, 2017, that resident #003's call bell was under their bed. The Inspector had to get onto their knees to observe the call bell which was under the middle of the residents bed.

On March 23, 2017, the Inspector observed that resident #003 was lying on their back in bed sleeping. The Inspector observed that the call bell remained under their bed.

On March 29, 2017, the Inspector interviewed PSW #124 who stated that the call bell should be kept within reach of the resident when they are in bed by attaching the call bell to the bed sheet, near the head of the bed.

On March 30, 2017, the Inspector interviewed the DOC who stated that the call bell should be kept within reach of the resident at all times when they are in bed, usually by attaching the call bell to the bed sheet. [s. 17. (1) (a)]

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 the home's resident-staff communication system is easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids labelled within 48 hours of admission and of acquiring, in the case of new items.

On March 20, 2017, during the initial tour of the home, Inspectors #612 and #642 observed in two of the home's tub rooms: one white tooth brush, used and unlabeled on the tub, as well as, one white used hairbrush and one used pink hairbrush, unlabelled on the counter top.

Between March 20, 2017 and March 22, 2017, Inspectors #620, #612, #679 and #642 identified thirteen resident rooms in three different units in which personal items, such as hair combs, toothbrushes, razors and toiletries were used and unlabelled in shared resident bathrooms.

During an interview with Inspector #679 on March 28, 2017, RN #118 said that it was the expectation of the home that all personal items were to have been labelled. [s. 37. (1) (a)]

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 each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items were offered and available at each meal and snack.

Inspector #642 observed the lunch meal on the two different dining rooms on March 20 and another dining room on different unit on March 24, 2017. Inspector #642 observed that the two choices for desserts (peach cake and fresh fruit) were not being offered to the residents. The two choices for desserts on March 24, 2017 were orange whip and fresh fruit.

Inspector #642 interviewed resident #025 on March 24, 2017 who stated that they were not offered a choice between the desserts.

The Inspector observed RPN #120 on March 24, 2017, placing the orange whip dessert in front of residents without offering the two dessert choices.

On March 30, 2017, Inspector #642 reviewed the home's policy titled "Dining Room Service" #93 effective March 2010, and under Position A: states the procedures for registered staff, "Ensure both desserts are offered."

The Inspector interviewed RPN #120 on March 24, 2017 who stated that they did not offer both desserts for lunch and indicated that they should have.

The Inspector interviewed the Food Services Manager on March 27, 2017, who stated that it was the home's process that residents were offered the planned menu items at each meals. [s. 71. (4)]

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 the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

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

On March 24, 2017, Inspector #679 observed RPNs #119 and #153 administering medications at a specific time on a specific unit.

During an interview with RPN #153 on March 24, 2017 at the time of the observations, they confirmed that they were still completing the medication pass that was initiated two and a half hours later than when it was supposed to be initiated. RPN #153 identified that resident #033 on the unit had yet to be given their medications which were scheduled two and half hours prior. In addition, resident #031 had not received a certain medication. Resident #018 and #028 had not had an assessment completed before certain medications were to be administered.

A review of the Electronic Medication Administration Record (eMAR), dated March 24, 2017 at the time of the observation identified that resident #033 had not received five of their medications which included three medications with a greater risk all at which were due two and a half hours earlier. In addition resident #031 had not received their one medication due two and a half hours earlier. Residents #018 and #028 had not had an

assessment documented prior to a certain medication which were due two and a half hours earlier.

Inspector #679 reviewed the medication administration details summary for the administration of resident #028's one medication over a one week period. The medication administration summary identified that on five of the seven days, one or more of the scheduled medications were administered greater than two hours from their scheduled time.

A review of the homes policy #38 entitled "Medication Administration", effective April 2006, identified that staff are to "take the prepared medication to the resident within a timely manner (usually 1 hour before or after the scheduled time)".

During an interview with RN #106 on March 30, 2017, regarding medication administration times. RN #106 stated that medications are expected to be administered within a window of 1 hour before and 1 hour after the medication is due.

On March 30, 2017, Inspector #679 interviewed the DOC regarding medication administration times. The DOC stated that it was the expectation of the home that medications were administered within a window of one hour before and one hour after the medication is due. The DOC identified that as per policy the medications were to be administered within in an appropriate amount of time. A review of resident #028's medication administration details summary identified that they were given their medications two hours late. In an interview with the DOC, they confirmed that these medication doses were not given in a timely fashion. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

A) On March 23, 2017, Inspector #542 observed the lunch dining service on a specific unit. The Inspector observed PSW #141 clearing soiled dishes, wiping resident's soiled mouths, removing soiled clothing protectors from residents, transporting a resident out of the dining room and then serving a resident their meal and fluids. PSW #141 was not observed to perform hand hygiene after handling the soiled items, or transporting residents out of the dining room.

On March 24, 2017, Inspector #612 observed the breakfast service on the same unit. The Inspector observed PSW #141 serving beverages, feeding residents, clearing dirty dishes, removing soiled clothing protectors and recording fluid consumption on a fluid intake sheet. The PSW did not perform hand hygiene during the meal service. During the lunch meal service, Inspector #612 observed PSW #141 was assisting a resident with eating their meal, cleaned dirty dishes from the table and then wipe their visibly soiled hands on their apron. The PSW then served a resident the dessert, removed some dirty dishes and then served other residents their dessert. PSW #141 did not perform hand hygiene at any time during the observations.

On March 24, 2017, Inspector #612 observed PSW #141 enter resident #027's room. The Inspector observed PSW #141 assist resident #027 with another PSW back into bed. PSW #141 finished assisting resident #027 and then proceeded to room another resident's room and started repositioning a resident's pillow. PSW #141 did not perform hand hygiene.

On March 24, 2017, Inspector #679 observed the noon medication pass on the same unit. The Inspector observed RPN #119 provide medications to three separate residents without performing hand hygiene in between each administration.

Inspector #612 reviewed the home's policy titled, "Hand Hygiene", policy number ICM-6,

last reviewed January 2017. The policy stated that hand hygiene should be performed before and after contact with any resident, their body substances or items contaminated by them, between different procedures on the same resident, before preparing, handling, serving or feeding a resident and to use soap and running water whenever hands were visibly soiled.

On March 28, 2017, Inspector #612 interviewed the Enhanced Care Program RN #131 who stated that the home follows the "Four Moments of Hand Hygiene", meaning that staff are expected to perform hand hygiene before and after resident contact. Hand hygiene should be implemented in the dining room between tasks (dirty to clean plates, between different residents), and during the medication pass the registered staff can assess hand sanitizer on the medication cart. The Enhanced Care Program RN #131 stated that staff can use the hand sanitizer accessible throughout the home or if hands are visibly soiled, wash hands with soap and water.

B) On March 28, 2017, Inspector #612 observed that room a specific resident's room had isolation bags, and isolation garb (gloves, gowns) hanging on the door. The Inspector was unable to observe a sign indicating the type of isolation.

The Inspector reviewed resident #008's progress notes which indicated that the resident was placed on contact isolation in the afternoon on a certain day.

On March 28, 2017, Inspector #612 interviewed RN #118 who stated that the appropriate signage should be posted on the door of the room on isolation and that staff should be following the "Isolation Checklist".

Inspector #612 reviewed the home's policy titled, "Procedure related to isolation" policy # OM-S3-01 which stated that staff are to post the appropriate signage. The Inspector reviewed the policy titled, "Isolation Checklist", policy number ICM-I-SI-06 and noted that the second task on the isolation checklist was to place the correct signage on the isolation room door.

The Inspector interviewed the DOC and the Infection Prevention and Control (IPAC) Lead who stated that there should be a sign posted on the door to indicate the type of isolation required and that should have been applied when the isolation was initiated. [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may have constituted a criminal offence.

Inspector #620 reviewed a CI report that was submitted to the Director, on a specific day, for alleged staff to resident physical abuse. The CI report indicated that resident #011 was found to have bruising to both wrists and hands bilaterally. The home documented in their report that the incident had occurred at a specific time on the same day that the CI report was submitted. For further details related to this incident refer to WN #2.

On March 24, 2017, Inspector #620 interviewed the Administrator, DOC, and the ADOC; all confirmed that the police had not been notified of the alleged incident of physical abuse. On the same day the Administrator notified Inspector #620 that they had notified the police of the incident.

Inspector #620 reviewed the home's policy titled, "Resident Abuse and Neglect – Zero Tolerance" with a last reviewed date of June 2016. The policy indicated that depending on the nature and severity of the alleged abuse, the Administrator/delegate was required to report incidents to various individuals or authorities. The policy advised that, "every licensee of a LTC home shall ensure that the appropriate police is immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. For physical abuse this means 9-1-1." [s. 98.]

Issued on this 27th day of July, 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) :	JENNIFER LAURICELLA (542), ALAIN PLANTE (620), AMY GEAUVREAU (642), MICHELLE BERARDI (679), SARAH CHARETTE (612)
Inspection No. / No de l'inspection :	2017_616542_0007
Log No. / Registre no:	003914-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 13, 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_572627_0030, 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 ensure that the care set out in the plan of care is provided to all residents as specified in the plan, specifically;

1) ensure that where wander strips are indicated in a resident's plan of care, they are applied correctly as described in their plan of care.

2) ensure that when specific fall prevention interventions are included in a resident's plan of care, that they are followed and,

3) ensure that a resident's plan of care is followed with respect to their required assistance with Activity of Daily Living (ADL) tasks.

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.

Compliance Order (CO) #001 was previously issued during inspection #2016_572627_0030, on February 22, 2017, with a compliance date of February 28, 2017.

The compliance order required the licensee to develop and implement a process to ensure that the care set out in the plan of care for resident #003, was provided to the resident as specified in the plan. The grounds of the order identified that resident #003 was to have a wander strip applied across their door.

Inspector #612 noted that resident #003, referred to in the compliance order, had been discharged from the home.

A) Inspector #612 observed resident #010's room on March 22, 2017, and noted that the resident had a wander strip attached to one side of the door way, but was not applied across the door. On March 23, 2017, the Inspector observed that the resident was sitting in their wheelchair in their room and that the wander strip was hanging down the door frame and not applied across the door.

On March 23, 2017, Inspector #612 interviewed resident #010 who stated that there were some residents on the unit who wander into their room, therefore, the staff would apply the wander strip to prevent these residents from entering their room. The resident stated that the wander strip should be applied at all times and confirmed that it was not currently applied across their doorway.

Inspector #612 reviewed the resident's electronic care plan and noted that it stated that the stop sign wander strip was to be applied to doorway at all times to deter wandering co-residents from entering.

On March 27, 2017, Inspector #612 interviewed PSW #124 who stated that the wander strip should have been applied across resident #010's doorway at all times.

B) On March 24, 2017, Inspector #612 observed on a specific unit at 0914 hours, resident #008 enter the room of another resident. Resident #008 entered the washroom, then went to bed A, then bed B and then exited the room and proceeded down the hallway. Resident #008 returned at 0920 hours and entered the same room again, and then exited and went into the dining room. At 0935 hours, RPN #116 applied the wander strip across the doorway of room that resident #008 entered.

At 0940 hours, resident #008 walked towards the same room and saw the wander strip applied across the door and then turned to enter the dining room. At 1420 hours, the Inspector observed that the wander strip was not across the doorway of the same room and resident #008 continued to wander the unit, and entered the room again.

Inspector #612 reviewed resident #008's printed care plan and noted that it

stated that the wander strip was to be in place across co-resident's rooms as resident #008 would often wander into other resident's rooms.

Inspector #612 reviewed resident #021's printed care plan and noted that it stated that the wander strip was to be applied to doorway at all times to deter wandering co-residents from entering.

Inspector #612 reviewed resident #022's printed care plan and noted that there was a hand-written intervention added March 20, 2017, which stated 'wander strip on door'.

C) On March 30, 2017, at 0930 hours, Inspector #612 observed that there was no wander strip applied across the doorway of resident #034's room. At 1130 hours, Inspector #612 again observed that there was no wander strip applied across the doorway. The Inspector observed resident #008 sleeping in resident #034's bed. At 1145 hours, RPN #116 noted that resident #008 was sleeping in resident #034's bed and asked a PSW to remove the resident and apply a wander strip across the doorway.

The Inspector reviewed resident #034's printed care plan and noted the following intervention, wander strip to be applied to doorway at all times to deter wandering co-residents from entering.

Inspector #612 interviewed PSW #115 on March 24, 2017, who stated that the wander strips should be applied across the doorway of resident's #021 and #022 room and resident #034's room to deter resident #008 from entering those rooms.

On March 31, 2017, Inspector #612 interviewed RPN #116 who stated that the wander strips should be applied across the door ways of resident #021 and #022's room as well as resident #034's room to prevent resident #008 from entering. RPN #116 stated that sometimes a resident may remove a wander strip, therefore staff have to constantly monitor the wander strips and reapply them across the doorways.

On March 30, 2017, Inspector #612 interviewed the Director of Care (DOC) who stated that resident #008 would often wander into other resident's rooms, therefore the wander strips were to be applied across the doorway to prevent resident #008 from entering the rooms. The DOC stated that the wander strips

should be applied across the doorway of the rooms as indicated in the care plans.

D) Inspector #620 conducted a review of a Critical Incident (CI) report that was submitted to the Director which indicated that resident #010 had a fall for which the resident was sent to the hospital which resulted in a significant change to the resident's condition. The report specified that the resident was diagnosed and treated for a fracture.

Inspector #620 reviewed the home's investigation related to the resident's fall which indicated that as a result of the fall, the resident's plan of care was altered to include two specific interventions.

Inspector #620 reviewed the resident's care plan that was current at the time of the inspection and identified one of the two interventions. The care plan also advised staff to, "document care being resisted on incidental Point of Care (POC). If resident refuses care, leave and return in 5-10 minutes."

On March 27, 2017, Inspector #620 interviewed resident #010 who indicated that one of the specific interventions was not in use and had not been applied for the last few days. They stated that they were unsure why.

Inspector #620 interviewed PSW #124 who indicated that the resident often refused to implement one of the specific interventions and that as a result they were not applied for a few days. PSW #124 stated that they did not document the refusal.

Inspector #620 reviewed the home's policy titled, "Falls Prevention and Management" with a last review date of June 14, 2016. The policy advised health care aides and personal support workers to, "follow procedures and care plan for high risk falls admissions" and, "report changes to registered staff." The policy also indicated that the intervention, was to be utilized to reduce fractures.

Inspector #620 interviewed the DOC who confirmed that resident #010's specific intervention had not been applied for, "some time." They indicated that the resident had a history of refusing. They told the inspector that the PSW staff should have documented the refusal in POC and notified registered staff. They said that the PSW staff should have attempted to persuade the resident to utilize the intervention on an ongoing basis, rather than discontinue the use.

E) Inspector #542 conducted a review of a Critical Incident (CI) report that was submitted to the Director for staff to resident abuse. Inspector #542 reviewed the CI report which indicated that resident #004 was found upset and crying and reported to RPN #147 that PSW #145 was rough and screamed at them. Resident #004 had asked PSW #145 to assist them to the bathroom as they were feeling weak, and the PSW refused. This resulted in resident #004 being incontinent, soiling themselves and their shoes. PSW #145 continued to refuse to assist the resident with any care.

Inspector #542 completed a review of the home's investigation regarding the incident. The investigation revealed that PSW #145 did not follow resident #004's care plan with regards to their continence care needs.

Inspector #542 reviewed the care plan that was in place at the time of the incident. It was documented that resident #004 required one to two staff extensive assistance to bring them to the bathroom, adjust clothing, and provide peri-care.

On March 28, 2017, Inspector #542 interviewed the DOC who indicated that PSW #145 did not follow the plan of care for resident #004 during this incident.

LTCHA, 2007 S.O. 2007, s. 6. (7) was previously issued during the following inspections:

- A Voluntary Plan of Correction (VPC) was issued on July 10, 2014 during a Resident Quality Inspection (RQI), inspection #2014_336580_0012;
- A VPC was issued on May 20, 2015 during a RQI, inspection # 2015_332575_0007;
- A Compliance Order (CO) was issued on June 20, 2016 during a RQI, inspection #2016_428628_0003 and
- A CO was issued on February 22, 2017 during inspection #2016_572627_0030 during a follow up inspection.

The decision to issue this compliance order was based on the scope which was widespread, the severity which indicated actual harm to the health and safety of residents and the compliance history which despite previous compliance orders, non compliance continues with this area of the legislation. (620)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that there is a written policy in place to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

Grounds / Motifs :

1. 1. The licensee had failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A) Inspector #542 conducted a review of a Critical Incident (CI) report that was submitted to the Director for staff to resident abuse. The CI report indicated that resident #004 was found upset and crying and reported to RPN #147 that PSW #145 was rough and screamed at them. See WN #2, finding three for further details.

Inspector #542 reviewed the progress notes for resident #004. It was documented a day prior to the submission of the CI report, that resident #004 was found upset and crying as PSW #145 yelled at them and was rough.

The home's investigation concluded that PSW #145 was emotionally abusive and neglectful towards resident #004. PSW #145 was terminated from their employment.

Upon review of the home's investigation file, another note for a different incident was located which indicated that resident #004 had stated that PSW #145 did not assist them with care and that they were rough with them.

On March 28, 2017, Inspector #542 and #620 interviewed the DOC. Inspector #542 asked if the home completed an investigation regarding the other allegation. The DOC indicated that the home completed a "reinstruction document" and did not complete further investigation regarding the alleged abuse. The DOC stated that if a resident accused a staff member of being rough, then further investigation should have occurred.

Inspector #542 reviewed the home's policy, titled, "Resident Abuse and Neglect – Zero Tolerance, last revised June 2016. It was documented in the policy that the home promotes a zero tolerance of abuse and neglect of residents by anyone.

B) Inspector #620 reviewed a CI report that was submitted to the Director on a specific day, at a specific time for alleged staff to resident physical abuse. The CI report indicated that resident #011 was found to have bruising to both wrists and hands, bilaterally. The home documented in their report that the incident had occurred five hours earlier on the day of the report being submitted.

A review of the home's investigation file revealed that the home had determined that PSW #105 was responsible for the injury to resident #011 and that the incident had been witnessed by PSW #148 on the evening shift the prior day to the submission of the CI report. In a documented interview conducted by the home, PSW #148 described that they heard PSW #105 speaking loudly to resident #011 in the resident's bathroom.

A review of the home's investigation revealed that on the evening before the submission of the CI report, PSW #148 failed to immediately report their observation of abuse; but rather, PSW #148 described the incident to PSW #149 and indicated that they were going to report it. The next day, RPN #147 discovered the bruising on resident #011 and documented the bruising in Point Click Care. RPN #147 suspected that an incident of abuse had occurred but did not report the suspicion until the end of their working day, when they notified RN #150.

Inspector #620 observed images of the injuries to resident #011's left and right wrist.

Inspector #620 reviewed the home's policy titled, "Resident Abuse and Neglect

– Zero Tolerance" with a last reviewed date of June 2016. The policy indicated that any person who suspected that abuse had occurred were required to immediately report their suspicion to the ADOC/DOC or Administrator, and if after-hours, the Manager on-call.

Inspector #620 interviewed the Assistant Director of Care (ADOC) who indicated that the home had determined that PSW #105 had abused resident #011. The ADOC also indicated that PSW #148 and RPN #147 failed to report the abuse immediately as required by the home's policy on zero tolerance of abuse. They indicated that PSW #105 was terminated as a result of the incident and that PSW #148 and RPN #147 were to receive discipline for failure to report.

A Voluntary Plan of Correction (VPC) was issued during inspection # 2015_391603_0010, March 23, 2015.

The decision to issue this compliance order was based on the severity of harm which was identified as actual harm to the residents, the scope which was identified as a pattern and the compliance history which despite previous non-compliance (NC), NC continues with this area of the legislation
(542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2017

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Order / Ordre :

The licensee shall ensure that, (a) drugs are stored in an area or a medication cart, (i) that is used exclusively for drugs and drug-related supplies, (ii) that is secure and locked, (b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that drugs were stored in an area or a medication cart, (i) that was used exclusively for drugs and drug-related supplies, (ii) that it was secured and locked and (iv) that complied with manufacturer's instructions for the storage of the drugs.

A) On March 20, 2017, during the initial tour of the home, Inspectors #612 and #642 observed in two different home area tub rooms: one used bottle of a medicated cream on the counter top with a worn out prescription label, as well as, 10 medicated creams in a basket.

On March 24, 2017, Inspector #612 observed a PSW linen cart outside of a resident's room on a specific unit. The Inspector observed three prescription creams on the cart. The PSW cart was out of site of the PSW. Subsequently, Inspector #679 observed an unattended linen cart in the hallway of the same home unit, outside of a resident's room with one tube of a medicated cream.

A review of the home's policy #84 titled "Administration of Prescription Products by UCP", effective April 2006, identified that PSWs are "to return product to the registered staff after each use for storage in the medication room or locked medication cart".

During an interview with Inspector #679, RN #118 identified that it was the home's expectation that all medicated creams were contained in a basket within the locked medication room.

During an interview with Inspector #678, the ADOC, stated that it was the home's expectation that all medicated creams were locked within the medication room.

B) On March 24, 2017 Inspector #679 observed an unattended and unlocked medication cart in one of the home's dining rooms at 1200 hours. The RPN was noted to be in a resident's room and did not have the cart in their view.

During an interview with Inspector #679, RPN #119 stated that the medication cart was required to be locked when it was not within eyesight of the RPN.

During a subsequent observation on March 24, 2017 at 1220 hours, Inspector #679 observed a medication cart, unlocked and unattended in another dining room for twenty-one minutes and out of sight of the RPN.

During an interview with Inspector #679, RPN #107 stated that the medication cart should have been locked.

Inspector #679 reviewed the electronic medication policy titled: "Medisystem pharmacy: Pharmacy policies and procedure manual for facilities in Ontario: Subject Medication Pass" last revised January 2017, which indicated "Do not leave the medication cart unattended at any time unless all medications are securely locked and resident information is secured on eMar/eTar."

During an interview with the ADOC on March 30, 2017, they identified that it was the home's expectation that the medication carts were locked at all times when unattended.

C) During an observation of the medication cart on March 27, 2017, with RPN #129. Inspector #642 observed a bottle of a certain medication that contained tablets that had expired in February 2017.

A review of the policy titled "Medisystem pharmacy: Pharmacy policies and procedure manual for facilities in Ontario: Pharmacy Section" last revised January, 2017, identified that "the following medications will be identified, destroyed and disposed of including: Expired medications."

RPN #129 identified that the pharmacy does an audit for expired products and confirmed that the expired medications should have been removed from the medication cart. [s. 129. (1) (a)]
(679)

2. 2. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in a locked area or stored in a separate locked area within a locked medication cart.

On March 28, 2017, Inspector #679 observed an unlocked refrigerator in a specific medication room. The refrigerator contained a small portable lock box which contained a controlled substance.

During an interview with Inspector #679, RPN #123 identified that the refrigerator was to remain locked.

A review of the homes policy titled "Medisystem pharmacy: Pharmacy policies and procedure manual for facilities in Ontario: Pharmacy section", last revised 2017 identified that "Narcotic and controlled substances must be stored in a double locked container in the medication cart or in the medication room."

During an interview with the ADOC on March 20, 2017, they identified that it was the home's expectation that the refrigerator containing the controlled substance was locked at all times. [s. 129. (1) (b)]

A Written Notification (WN) was issued during inspection # 2015_332575_0007

in 2015, along with a Voluntary Plan of Correction (VPC) during inspection # 2016_428628_0003, in February, 2016.

The decision to issue this Compliance Order (CO) was based on the severity of harm in which there was a potential for harm, the scope which was determined to be a pattern. Despite previous non compliances, the home continues have non compliances in this area of the legislation.
(679)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 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 13th day of June, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Lauricella

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