**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 prévue 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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Dec 20, 2018 | 2018_786744_0001 | 006181-18, 006474-18, 013117-18 | Critical Incident System |

### Licensee/Titulaire de permis

Finlandia Nursing Home Limited
c/o Sudbury Finnish Rest Home 233 Fourth Avenue SUDBURY ON P3B 4C3

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

Finlandia Hoivakoti Nursing Home
233 Fourth Avenue SUDBURY ON P3B 4C3

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

STEVEN NACCARATO (744), RYAN GOODMURPHY (638)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): December 10-14, 2018**

**The following intakes were inspected during this Critical Incident System (CIS) inspection:**
**-One intake related to a critical incident the home submitted to the Director regarding a fall in which the resident was taken to hospital as a result of a fracture;**
**-Two intakes related to critical incidents the home submitted to the Director regarding an outbreak of a disease.**

**A Critical Incident Inspection #2018_782736_0001 was conducted concurrently with this CIS inspection.**

**During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW), and residents.**

**The Inspectors also conducted a daily tour of the resident care areas, reviewed relevant health care records, reviewed home policies and procedures, observed resident rooms, common areas, and observed staff to resident interactions.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Infection Prevention and Control**

**During the course of this inspection, Non-Compliances were issued.**
**1 WN(s)**
**0 VPC(s)**
**0 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| **NON-COMPLIANCE / NON - RESPECT DES EXIGENCES** | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):**
**5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances, of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Inspector #744 reviewed a Critical Incident Systems (CIS) report that was submitted to the Director, related to an outbreak in the home. It was identified that the outbreak was declared a day before the report to the Director.

Inspector #744 interviewed RN #106, who stated that once Public Health declared an outbreak, they would notify the DOC, or the manager on call if the outbreak was declared after hours.

The home's policy titled "Mandatory Reporting To The MOHLTC– NM-Form-1" last revised September 2017, states that an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion, required an immediate initiation of the on-line MCIS form or a report to the after hours pager.

In an interview with Inspector #744, the DOC stated that the monitoring of daily symptoms of infections were completed by the direct care staff. If symptoms of infection were present, Public Health would have been notified by the RN of the daily symptoms. The DOC or the ADOC were to report to the Director once an outbreak was declared. The Inspector reviewed the outbreak that was declared on a specified date, with the DOC. Upon review, they identified that the outbreak declared by Public Health on the specified date, should have been reported immediately, but was reported the next day. [s. 107. (1) 5.]

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**Issued on this 27th day of December, 2018**

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

**Original report signed by the inspector.**