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 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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 6, 2019	2019_671684_0021	033405-18	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

SHELLEY MURPHY (684)

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): June 4, 2019.

The following intakes were inspected during this Critical Incident System (CIS) inspection:
-One Intake related to a CI report that the home submitted to the Director for an incident that caused an injury to a resident which resulted in a significant change in the resident's health status.

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

The Inspector also conducted a tour of resident care areas, observed staff to resident interactions, reviewed relevant resident health care records, reviewed relevant internal investigation records, licensee policies, procedures, and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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

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	Légende 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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A Critical Incident (CI) report was submitted to the Director on a specified day in 2018, for an incident that caused an injury to a resident, resulted in a significant change in the resident's health status. The CI report indicated that resident #001 was injured while (Personal Support Worker) PSW #104 and #105 were transferring the resident to provide a care plan intervention.

Inspector #684 reviewed the progress notes for resident #001 which indicated an incident occurred while care was being provided to resident #001 by two staff members who were transferring the resident.

Inspector #684 interviewed PSW #104 who stated what occurred during the transfer of resident #001 with PSW #105.

Inspector #684 reviewed the care plan that was in place for resident #001 at the time of the incident specific to their transferring requirments.

Inspector #684 reviewed the home's policy titled "Body Mechanics, NM-S-2", last revised November 2, 2017 which provided directions for safe transferring techniques when assisting residents.

Inspector #684 reviewed a typed letter to PSW #105, from a specified date in 2018, signed by Assistant Director of Care (ADOC) #102. The letter stated the incident specifics which occurred while providing care to resident #001 which resulted in an injury to the resident.

During an interview with the Administrator, Inspector #684 reviewed the care plan for resident #001 and home's policy titled “Body Mechanics” which was in place at the time of the incident. The Administrator confirmed that PSW #105 did not follow the care plan as well as the home's policy for Body Mechanics.

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 staff use safe transferring and positioning techniques when assisting residents, to be implemented voluntarily.

Issued on this 2nd day of July, 2019

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

Original report signed by the inspector.