Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: September 22, 2023
Inspection Number: 2023-1314-0003
Inspection Type: Critical Incident
Licensee: Finlandia Nursing Home Limited
Long Term Care Home and City: Finlandia Hoivakoti Nursing Home, Sudbury

Lead Inspector	**Inspector Digital Signature**
Samantha Fabiilli (000701)	Samantha Fabiilli Digitally signed by Samantha Fabiilli Date: 2023.10.12 15:24:05 -04'00'

Additional Inspector(s)
Jean-Pierre Nabarra de Bénéjacq (000702)
Keara Cronin (759) was also in attendance for this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 15 -17, 2023

The following intake(s) were inspected:

- One Intake related to a fall of a resident.
- One Intake related to an incident of a resident resulting in a transfer to hospital.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a residents plan of care was reviewed and revised when their care needs changed.

Rationale and Summary:
An incident occurred while providing resident care, which resulted in a resident being transferred to hospital.

A staff member indicated that a resident had been provided care using a specific piece of equipment. However, the residents plan of care at the time of the incident, did not identify the use of this equipment. The Director of Care (DOC) indicated that the plan of care, at the time of the incident, was not updated to reflect the resident's care needs.

There was minimal risk to the resident from the non-compliance, as although staff indicated this piece of equipment was required for resident it was not indicated in a residents plan of care.

Sources: A residents care plan; A residents census; Interviews with staff and DOC; A residents progress notes; A Critical Incident Report.
[000702]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that resulted in a significant change to a resident’s health condition.

Rationale and Summary:
An incident occurred that resulted in a change to a resident's status.

However, a Critical Incident (CI) report was not submitted to the Director until two weeks after the incident occurred. Assistant Director of Care (ADOC) acknowledged that the CI report was reported late.

Late reporting of the critical incident resulted in no risk and no impact to the resident.

Sources: Interviews with staff and ADOC; Review of a residents progress notes; A Critical Incident Report.
[000701]