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: July 15th 2024	
Inspection Number: 2024-1314-0001	
Inspection Type: Critical Incident	
Licensee: Finlandia Nursing Home Limited	
Long Term Care Home and City: Finlandia Hoivakoti Nursing Home, Sudbury	
Lead Inspector Justin McAuliffe (000698)	**Inspector Digital Signature** Justin Christopher Mcauliffe Digitally signed by Justin Christopher Mcauliffe Date: 2024.07.16 13:34:31 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 8 to 10, 2024
The following intake(s) were inspected:

- An intake related to an ARI outbreak.
- An intake related to an Enteric outbreak.
- An intake related to an Enteric outbreak.
- An intake related to an event in which a resident suffered an injury.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Pain management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee has failed to ensure that the monitoring of the effectiveness of pain management strategies implemented for a resident were completed.

Rationale and Summary
During record review of the resident's progress notes, it was stated that a medication was provided for pain. However, there were no pain assessments or documentation completed to evaluate the effectiveness of the medication provided for pain management. In interviews with staff members, they acknowledged that there were no pain assessments or documentation completed to evaluate the effectiveness of the medication provided for pain management. The staff members also noted that the expectation is to assess the resident accordingly and to document the effectiveness of the pain management in the resident's clinical record.

The home's failure to monitor the effectiveness of the pain management strategies implemented for the resident, posed a low risk to the resident.

Sources
Resident's clinical records; Interview with staff. [000698]

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 (1) 5.
Reports re critical incidents
s. 115 (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 (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed when an enteric outbreak was declared in the home.

Rationale and Summary
An enteric outbreak was declared in the home. The Director was not notified of this outbreak until several days later. In an interview with staff members, they acknowledged the reporting requirements for outbreaks and acknowledged that the Director should have been notified immediately.

By not ensuring the Director was immediately informed when an enteric outbreak was declared in the home, there was risk to residents.

Sources: Critical Incident Reports; interviews with staff. [000698]