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

Public Report

Report Issue Date: March 14, 2025
Inspection Number: 2025-1314-0002
Inspection Type: Critical Incident
Licensee: Finlandia Nursing Home Limited
Long Term Care Home and City: Finlandia Hoivakoti Nursing Home, Sudbury

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 10-14, 2025.

Two intakes were inspected:
-One intake related to allegations of resident to resident abuse; and
-One intake related to a resident who fell.

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

Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Required Programs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that in accordance with Ontario Regulation (O. Reg) 246/22 s. 11 (1) (b), a Personal Support Worker (PSW) complied with the home's falls prevention and management program when they failed to correctly implement one of a resident's fall interventions.

Sources: The home's policy titled "Falls Prevention And Management" last revised June 5, 2024, a resident's post-fall and fall risk assessments, interviews with an Assistant Director of Care (ADOC) and other staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (a)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;

The licensee has failed to ensure that two residents' behavioural triggers were identified in their plans of care.

Sources: Two residents' health care records and plans of care, the home's policy titled "Prevention And Treatment Of Responsive Behaviour" last reviewed November 5, 2024, interviews with an ADOC and other staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 4. i.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and

The licensee failed to ensure that a CI report included the the immediate actions taken to prevent a similar incident from reoccurring.

Sources: A CI report, The home's policy titled "Mandatory Reporting To The MOHLTC" last revised October 30, 2024, interviews with an ADOC and other staff.

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