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
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Public Report

Report Issue Date: January 7, 2026
Inspection Number: 2025-1314-0004
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): December 16 -19, 2025

The following intake(s) were inspected:

- One intake related to the fall of resident,
- One intake related to resident-to-resident physical abuse, and
- Two intakes related to resident-to-resident abuse.

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

Responsive Behaviours
Restraints/Personal Assistance Services Devices (PASD) 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 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

A resident required the use of a personal assistance service device (PASD) to support mobility and transferring. However, the resident's written plan of care did not identify their PASD, not did it include clear directions for device usage.

Sources: Observations during the inspection; resident health care records; the home's policy; and interviews with a Registered Practical Nurse (RPN) and Assistant Director of Care (ADOC).

WRITTEN NOTIFICATION: Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
2. The outcomes of the care set out in the plan of care.

On a specified date, an incident occurred between two residents which was not documented by Personal Support Workers (PSW) as prompted in the residents' Point-of-Care (POC) charting.

Sources: Resident health care records; and interviews with a Registered Nurse (RN) and Director of Care (DOC).

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

An RN witnessed a potential abuse incident between two co-residents on a specified date. Approximately 30 minutes later, the RN learned of a second incident of potential abuse involving one of the same residents and a third co-resident. Both incidents were

not report to the Director until the next day.

Sources: The home's policy titled "Resident Abuse And Neglect - Zero Tolerance"; Critical incident (CI) reports; and an interview with an RN.

WRITTEN NOTIFICATION: Responsive behaviours

NC #004 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;

A resident became physically responsive towards a co-resident related to a specific situation. The triggers related to the specific situation were not identified in the resident's plan of care.

Sources: The home's policy titled "Plan Of Care And Resident Care Plan"; resident health care records; and interviews with a PSW and DOC.

WRITTEN NOTIFICATION: Responsive behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

On a specified date, a resident exhibited responsive behaviours towards a co-resident. No actions were taken to increase monitoring after the first incident, which led to a second occurrence 30 minutes later involving another co-resident.

Sources: The home's policy titled "Prevention And Treatment Of Responsive

Behaviour"; CI reports; resident health care records; and interviews with a PSW, RPN, RN, and DOC.

WRITTEN NOTIFICATION: Notification re incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (b)
Notification re incidents
s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

An RN did not notify the Substitute Decision-Makers for three residents involved in two incidents of potential resident-to-resident abuse within 12 hours of the licensee becoming aware of the incidents.

Sources: The home's policy titled "Resident Abuse And Neglect - Zero Tolerance"; CI reports; resident health care records; and interviews with an RN and DOC.