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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 20, 2014	2014_282543_0015	S-000327-13,000270-13	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 LIMITED
233 FOURTH AVENUE, SUDBURY, ON, P3B-4C3

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

TIFFANY BOUCHER (543), MONIKA GRAY (594)

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): May 27th-29th, 2014

Ministry of Health and Long-Term Care logs: S-000270-13, 000327-13, 000542-13, 000158-14, 000160-14, 000166-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Staff (RNs and RPNs), Personal Support Workers (PSW).

During the course of the inspection, the inspector(s)
- Directly observed the delivery of care and services to residents
- Conducted daily tour of all resident home areas
- Reviewed resident health care records
- Reviewed various home policies and procedures
- Reviewed staff education attendance records

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

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	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Inspector #543 reviewed critical incident report #2829-000033-13. According to the critical incident, on October 23rd, 2013, the RN received a complaint from resident #002's family and filled out a "concern/complaint form". The Assistant Director of Care (ADOC) was made aware of the concern on October 25th, 2013. The RN reported to the ADOC that resident #002's family expressed great concern regarding the care the resident received on the night of October 18th, 2013. On October 25th, 2013, ADOC initiated an investigation with all the staff involved. The staff informed the ADOC of the following:

- On October 18th, 2013, at 23:30, the personal support worker 1 (PSW1) had been told by the Registered Practical Nurse (RPN) that they would be back from break in 30 minutes
- On October 18th, 2013 , at approximately 23:45 resident #002 began asking for pain medication
- On October 25th, 2013, the PSW #1 told the ADOC that resident #002 continued to yell out that they could not breathe. The PSW #1 waited until 01:30 before trying "to get a hold of the RPN", only after speaking with another PSW #2. Once the RPN was made aware of resident #002's request for pain medication, the RPN prepared the medication and it was administered at 01:40. Resident #002 reportedly resettled until approximately 04:00, when resident #002 felt unwell and vomited. According to progress notes, the RPN assessed the resident at 05:00. Assessment indicated that the resident was in respiratory distress. Resident #002's family was notified due to this resident's decline in condition. According to resident #002's progress notes at 05:15, the resident was transferred to the hospital and admitted.

Inspector #543 reviewed the home's Policy-Resident Abuse and Neglect-Zero Tolerance (ID-20) and the policy indicated that residents will be free from abuse and neglect by staff, volunteers, visitors and other residents. The policy also stated, the failure to provide a resident with treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. This may include, but not limited to; the withholding of appropriate treatment of prescribed drugs.

Consequently, the licensee failed to ensure that resident #002 was not neglected by staff. [s. 3. (1) 3.]

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 residents in the home are not neglected by staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. Inspector #543 reviewed critical incident report #2829-000033-13. According to the critical incident, on October 23rd, 2013, the RN received a complaint from resident #002's family and filled out a "concern/complaint form". The Assistant Director of Care (ADOC) was made aware of the concern on October 25th, 2013. The RN reported to the ADOC that resident #002's family expressed great concern regarding the care the resident received on the night of October 18th, 2013. On October 25th, 2013, ADOC initiated an investigation with all the staff involved. The staff informed the ADOC of the following:

• On October 18th, 2013, at 23:30, the personal support worker 1 (PSW1) had been told by the Registered Practical Nurse (RPN) that they would be back from break in 30 minutes
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• On October 25th, 2013, the PSW #1 told the ADOC that resident #002 continued to yell out that they could not breathe. The PSW #1 waited until 01:30 before trying "to get a hold of the RPN", only after speaking with another PSW #2. Once the RPN was made aware of resident #002's request for pain medication, the RPN prepared the medication and it was administered at 01:40. Resident #002 reportedly resettled until approximately 04:00, when resident #002 felt unwell and vomited. According to

progress notes, the RPN assessed the resident at 05:00. Assessment indicated that the resident was in respiratory distress. Resident #002's family was notified due to this resident's decline in condition. According to resident #002's progress notes at 05:15, the resident was transferred to the hospital and admitted.

Inspector #543 reviewed the home's Policy-Pain Management (NM-A-9) which identified that Finlandia Nursing Home (FNH) recognizes the right of each resident to pain assessment and management, appropriate to their age and condition. The home's policy also stated that pain management is the responsibility of all clinical disciplines. FNH recognizes its responsibility to plan, support, and coordinate activities and resources to assure that the pain of all residents is recognized and addressed appropriately. Inspector #543 reviewed the home's Policy-Resident Abuse and Neglect-Zero Tolerance (ID-20) and the policy indicated that residents will be free from abuse and neglect by staff, volunteers, visitors and other residents. The policy also stated, the failure to provide a resident with treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents constitutes negelct. This may include, but not limited to; the withholding of appropriate treatment of prescribed drugs.

Consequently, the licensee failed to ensure that the policy- Resident Abuse and Neglect-Zero Tolerance (ID-20) was complied with. [s. 20. (1)]

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 the policy, Resident Abuse and Neglect-Zero Tolerance (ID-20)is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. Inspector #543 reviewed home's direct care staff education records for the year 2103 and identified that 15% of Registered Nurses (RN) and 4% of Personal Support Workers (PSW) did not complete annual re-training in regards to the home's policy-Resident Abuse and Neglect-Zero Tolerance (ID-20).

Consequently, the licensee failed to ensure that all staff received retraining annually relating to the home's policy- Resident Abuse and Neglect-Zero Tolerance (ID-20). [s. 76. (4)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
1. That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

Findings/Faits saillants :

1. According to Critical Incident 2829-000007-14, one box of 10 Hydromorphone 2mg/mL was discovered missing from the narcotic destruction lock box on April 08, 2014. It was confirmed that "three of three boxes" had been placed into the narcotic destruction lock box for destruction. Inspector #594 reviewed policy "Inventory Control-Drug Disposal", #02-06-20 which identified "Drugs that are to be destroyed and disposed of are to be stored safely and securely." On May 28, 2014 Inspector #594 observed the narcotic destruction lock box in the Koivu nursing station medication room. This narcotic destruction lock box is bolted to the adjacent counter. A 2cm slot the length of the narcotic destruction lock box is located at the top of the front of the narcotic destruction lock box which is intended for medication cards. A PVC pipe that bends to the right within the narcotic destruction lock box and opens to the exterior, is located below the slot. The purpose of the PVC pipe is for the disposal of larger boxed/bottles of medications. Despite the controlled medications being in a locked narcotic destruction lock box within the locked medication room, Inspector #594 was able to extend their hand through the opening of the PVC pipe to reach within the locked wooden box.

Consequently, the licensee did not ensure that drugs were destroyed and disposed and stored safely and securely within the home. [s. 136. (2) 1.]

Issued on this 20th day of June, 2014

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