Ontario

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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 24, 2015	2015_331595_0009	S-000796-15, S-000578-14, S-000631-14	Critical Incident System

Licensee/Titulaire de permis

THE ONTARIO-FINNISH RESTHOME ASSOCIATION
725 North Street Sault Ste Marie ON P6B 5Z3

Long-Term Care Home/Foyer de soins de longue durée

MAUNO KAIHLA KOTI
723 North Street Sault Ste Marie ON P6B 6G8

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

MARINA MOFFATT (595)

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 13 & 14, 2015

The following MOHLTC logs were inspected: S-000578-14, S-000631-14, S-000796-15.

During the course of the inspection, the inspector(s) spoke with Executive Director of Care (EDOC), Registered and Non-Registered staff and Residents.

Throughout the inspection, the inspector completed health care record reviews, observations, and review of the home's policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's identity, was respected.

Inspector #595 reviewed a Critical Incident (CI) report which outlined an alleged incident of staff-to-resident abuse. The report described that S #103 was verbally abusive towards resident #002. S #111 was in the resident's bathroom when the incident occurred. It was alleged that S #103 yelled at the resident "Don't talk to me like that! You need to be more respectful". S #111 then heard the resident apologizing to the staff. S #103 left and returned to the resident's room with additional ordered medication, and when the resident asked about the medication, then S #103 stated "You don't have to be rude, you don't talk to us like that, you say please and thank you". S #111 did not report the incident until four days later.

Inspector #595 reviewed the investigation package as provided by the EDOC. It was identified in the investigation package that there were conflicting accounts of the incident. Contrary to S #111's report, S #115 stated that they were on the specific resident home area at the time of the incident, and claimed that resident #002 was rude towards S #103, and that the staff simply responded that they would get their additional dose of medication and that they did not have to get upset.

Inspector #595 reviewed resident #002's care plan. It was outlined that the resident could exhibit behaviours and that staff were to remind the resident that inappropriate language was unacceptable. It was identified in the investigation package that the resident's POA wasn't worried about the situation, and that they knew the resident could be rude to staff and they figured the resident had been rude to staff or yelled at them.

Inspector reviewed the investigation package in which the home concluded that although the staff member denied yelling at the resident, they did speak to them in an abrupt, loud manner (stern voice). [s. 3. (1) 1.]

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. The licensee failed to ensure that there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with.

Inspector #595 reviewed a Critical Incident (CI) report which outlined an alleged incident of staff-to-resident abuse. The report described that S #103 was verbally abusive towards resident #002. S #111 was in the resident's bathroom when the incident occurred. It was alleged that S #103 yelled at the resident "Don't talk to me like that! You need to be more respectful". S #111 then heard the resident apologizing to the staff. S #103 left and returned to the resident's room with additional ordered medication, and when the resident asked about the medication, then S #103 stated "You don't have to be rude, you don't talk to us like that, you say please and thank you". S #111 did not report the incident until four days later.

Inspector reviewed the home's policy 'Abuse of Residents, Preventing, Reporting, & Eliminating' (revised February 2015). It was identified that employees who witness or suspect the abuse of a resident are to report the matter immediately to their direct supervisor, who, in turn, reports the same to the Director of Care (DOC) and/or Chief Executive Officer (CEO). Additionally, it was noted that any person may report witnessed or suspected abuse to any of the following: DOC or CEO of the Ontario Finnish Resthome Association; Ministry of Health and Long-Term Care; Long-Term Care Action Line.

Inspector #595 spoke with S #111 who confirmed that they did not report the suspected abuse immediately. The staff identified that they reported the incident the next day they were in to work, which was four days after the incident occurred. The staff also stated that they should report an incident or suspicion of resident abuse to staff right away. [s. 20. (1)]

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Issued on this 26th day of June, 2015

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

Original report signed by the inspector.