Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
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159, rue Cedar Bureau 403
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 17, 2021	2021_822613_0018	010275-21	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

LISA MOORE (613)

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): August 3-6, 2021.

The following intake was inspected during this Inspection:

One intake that was submitted to the Director regarding a resident to resident incident resulting with an injury and transfer to the hospital.

During the course of the inspection, the inspector(s) spoke with the Executive Director of Care (EDOC), Facility Manager (FM), Environmental Service Supervisor (ESS), Registered Nurses (RN Supervisors), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Behavioural Supports Ontario PSW (BSO PSW) and residents.

The Inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, investigation files, video surveillance and reviewed relevant policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **1 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	Légende 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was protected from abuse by another resident.

Physical abuse is defined within Ontario Regulation 79/10 as, the use of physical force by a resident that causes physical injury to another resident.

A resident had an altercation with another resident that caused a resident to fall sustaining an injury that required a transfer to the hospital.

The resident had a history of responsive behaviours which various staff members indicated they were aware.

The strategies for managing a resident's responsive behaviours failed to prevent abuse towards another resident and resulted in actual harm.

Sources: CIS report; the home's investigation notes; the home's video surveillance; the licensee's Abuse of Residents, Preventing, Reporting & Eliminating policy; residents' plan of care and interviews with the EDOC and other staff. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Preventing Heat-Related Illnesses policy was in compliance with all applicable requirements under the Act.

O. Reg. 79/10, s. 21 (2) and O. Reg. 79/10, s. 21 (3)., requires that temperature be measured and documented in writing, at a minimum in the following areas of the home:

1. At least two resident bedrooms in different parts of the home.
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.
3. Every designated cooling area, if there are any in the home., and;
4. the temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The licensee's policy titled, “Monitoring the Air Temperature in Mauno Kaihla Koti” did not identify an approved or revised date. The policy did not outline a process for obtaining temperature readings in all the required areas or at the required specified times as outlined in Ontario Regulation 79/10.

The Facility Manager verified this was the most current version of the policy and that it had not been revised.

Sources: April 1, 2021 memo regarding amendments to Ontario Regulation 79/10 related to enhanced cooling requirements; Mauno Kaihla Koti Daily Checklist for Housekeeping and MKK Room Temperature Report; interview with the Facility Manager. [s. 8. (1)]

2. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 48. (1) 1., the licensee was required to ensure that a falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented in the home.

Specifically, staff did not comply with the licensee’s Falls Management policy.

The licensee’s policy identified that registered staff were not to move the resident’s position or assist them from the floor until the possibility of injury was eliminated and after

an assessment was completed.

A resident had a physical altercation with another resident that caused a resident to fall. The resident informed a RPN and PSW that they had an injury while they were on the floor; however, the RPN and PSW assisted the resident with a transfer prior to completing the assessment.

The EDOC confirmed that staff did not comply with the licensee's Falls Management policy.

The failure of a RPN and PSW not following the licensee's Falls Management policy put a resident at risk for further injury.

Sources: CIS report; the home's investigation notes; the home's video surveillance; the licensee's Falls Managing policy; a resident's plan of care and interviews with the EDOC and other staff.[s. 8. (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 the Falls Management policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
11. Seasonal risk relating to heat related illness, including protective measures required to prevent or mitigate heat related illness. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents' plans of care were based on an interdisciplinary assessment of their seasonal risks related to hot weather.

The licensee's policy titled, “Hot Weather-Related Illness, Preventing and Managing” (0309-01) last updated June 2021, identified the RN Supervisor or RPN Team Lead completed the risk assessment and determined whether the resident was potentially at increased risk or at increased risk during hot weather and risk factors were documented in the residents' care plans.

The Inspector reviewed random resident care plans which did not indicate heat risk assessments or protective measures.

A review of an email provided by the EDOC, identified that the home did not have any direction for specific heat related needs for the residents.

A RPN verified they were completing a heat risk assessment tool and updating all resident care plans. The licensee policy and resident care plans were updated during this inspection.

The failure of RN Supervisors and RPN Team Leads not ensuring that residents' plans of care were based on an interdisciplinary assessment of their seasonal risks related to hot weather put all residents at risk of harm.

Sources: Hot Weather-Related Illness, Preventing and Managing policy; Email; and interviews with EDOC and a RPN. [s. 26. (3) 11.]

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' plans of care are based on an interdisciplinary assessment of their seasonal risks related to hot weather, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).
3. Every designated cooling area, if there are any in the home. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that temperatures were measured and documented in writing, at a minimum in two resident bedrooms in different parts of the home, one resident common area on every floor of the home and every designated cooling area.

Amendments to Ontario Regulation 79/10 under the Long-Term Care Homes Act, 2007, related to enhanced cooling requirements, was sent April 1, 2021, with an effective date of May 15, 2021. These amendments required Long-Term Care Home's to measure and document the air temperature, at a minimum, in certain specified areas in the Long Term Care home at specified intervals.

The Facility Manager identified that air temperatures were monitored in different locations in the home, which included two resident rooms and a common area or cooling area, but each area did not always have the air temperature monitored or documented daily. The Facility Manager verified that the housekeeping and maintenance staff did not obtain temperature readings in all the required areas.

The failure of the housekeeping and maintenance staff to monitor and document the air temperatures of at least two resident bedrooms in different parts of the home, one resident common area on every floor of the home and every designated cooling area, put the resident's at risk for developing a heat related illness, as the home would be unable

to identify where there was an air temperature concern.

Sources: April 1, 2021 memo regarding amendments to Ontario Regulation 79/10 related to enhanced cooling requirements; Mauno Kaihla Koti Daily Checklist for Housekeeping and MKK Room Temperature Report; interview with the Facility Manager. [s. 21. (2)]

2. The licensee has failed to ensure that temperatures required to be measured under subsection (2) were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

A review of the licensee's documents titled, "Mauno Kaihla Koti Daily Checklist for Housekeeping" and "MKK Room Temperature Report" failed to demonstrate that air temperatures were being taken and documented three times daily.

The Facility Manager verified that the housekeeping and maintenance staff were not documenting temperatures as required by the regulation.

The failure of the housekeeping and maintenance staff not documenting the air temperatures at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, put the resident's at risk for developing a heat related illness, as the home would be unable to identify when there was an air temperature concern.

Sources: April 1, 2021 memo regarding amendments to Ontario Regulation 79/10 related to enhanced cooling requirements; Mauno Kaihla Koti Daily Checklist for Housekeeping and MKK Room Temperature Report; interview with the Facility Manager. [s. 21. (3)]

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 18th day of August, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	LISA MOORE (613)
Inspection No. / No de l’inspection :	2021_822613_0018
Log No. / No de registre :	010275-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 17, 2021
Licensee / Titulaire de permis :	The Ontario-Finnish Resthome Association 725 North Street, Sault Ste. Marie, ON, P6B-5Z3
LTC Home / Foyer de SLD :	Mauno Kaihla Koti 723 North Street, Sault Ste. Marie, ON, P6B-6G8
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Paul Belair

To The Ontario-Finnish Resthome Association, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19. (1) of the LTCH Act, 2007.

Specifically, the licensee must ensure:

A) All residents are protected from abuse by anyone.

B) A resident's written strategies to prevent, minimize or respond to their responsive behaviours are reviewed and revised weekly, or in the event of a significant change, to determine if effective or ineffective to reduce the risk of altercations and potentially harmful interactions between and among other residents; and,

C) A documented record is kept of all reviews, including the date and a record of any changes made. This will commence immediately and end when a resident no longer poses a risk to other residents or requires heightened monitoring by staff.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident was protected from abuse by another resident.

Physical abuse is defined within Ontario Regulation 79/10 as, the use of physical force by a resident that causes physical injury to another resident.

A resident had an altercation with another resident that caused a resident to fall sustaining an injury that required a transfer to the hospital.

The resident had a history of responsive behaviours which various staff members indicated they were aware.

The strategies for managing a resident's responsive behaviours failed to prevent abuse towards another resident and resulted in actual harm.

Sources: CIS report; the home's investigation notes; the home's video surveillance; the licensee's Abuse of Residents, Preventing, Reporting & Eliminating policy; residents' plan of care and interviews with the EDOC and other staff.

An order was made by taking the following factors into account:

Severity: A resident had an incident of responsive behaviours in which planned interventions were ineffective, leading to an incident and actual harm to another resident. The other resident was injured and experienced a significant change in their health status.

Scope: The scope of non-compliance was isolated to a resident.

Compliance History: There was no previous history in the past 36 months (613)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 18, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 17th day of August, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Moore

Service Area Office /
Bureau régional de services : Sudbury Service Area Office