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 |
|---|---|---|---|
| Jan 29, 2016 | 2016_428628_0002 | 000601-16 | 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

MARIE LAFRAMBOISE (628)

## 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): January 13, 14, 15, 2016**

**This inspection was related to a Critical Incident Report (CI) submitted to the Director related to a resident fall whereby the resident passed away.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Chief Clinical Officer, the Director of Care, a Charge Nurse, a Registered Practical Nurse (RPN) and four Personal Support Workers (PSW).**

**The Inspector observed the room where the fall occurred, reviewed various policies and procedures, annual program evaluations, staffing records and resident health care records.**

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

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

Inspector #628 reviewed CI report related to a critical incident where by a resident fell. The resident was transferred to the hospital and later passed away.

The Physician Orders for the resident were reviewed which identified the resident was on more than five medications on admission including Aspirin.

The multi-disciplinary team member completed a three month quarterly review on a single sheet of paper which identified recent health condition changes and made recommendations regarding medication changes and interventions.

The documented progress notes and orders, related to the three month medical review indicated, "TMMR complete. 0 changes noted." There was no record that the multi-disciplinary team member's recommendations, related to recent condition and medication changes, had been reviewed.

The DOC was interviewed and was requested to forward to the inspector the written policy or procedure regarding the multi-disciplinary team member's process for quarterly medication reviews, how the multi-disciplinary team members would make recommendations and the process to verify that written recommendations had been received and reviewed. The policy was received by the inspector and the policy requirements by the multi-disciplinary team were reviewed.

Another policy, from the home documented a different process from the multi-disciplinary team member's policy for the Three Month Medication Reviews (TMR).

The policies reviewed did not document a process for the completion of quarterly medication reviews, including multi-disciplinary team member's recommendations and the verification process that recommendations had been provided, received and reviewed by the physician.

Inspector #628 interviewed the DOC who stated that multi-disciplinary team member's Quarterly Reviews were to be clipped to the TMR and reviewed and that there was no

documented confirmation available that recommendations had been received or reviewed by the physician.

Consequently, the licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other. [s. 6. (4) (a)]

***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 staff and others involved in the different aspects of care collaborate with each other in the assessment of residents, so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.***

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**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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is:
(b) complied with.

The licensee's "Falls Prevention and Management" policy was reviewed. The policy

stated that a falls risk assessment was required, specifically the Morse Fall Scale, to be conducted by staff within 24 hours of admission. This policy required that residents that took more than five medications, should be identified as high risk for falls. The policy also stated that residents on anticoagulants should be monitored after a fall for possible hematoma.

The resident's (TMR) was reviewed and indicated that the resident was prescribed at least 11 medications, including Aspirin on admission. Later, an anticoagulant medication was also prescribed. The resident was on more than five medications throughout the duration of having resided in the home.

The Morse Fall Scale was done 2 days after admission and indicated the resident was at a low risk for falls. A subsequent post fall assessment, whereby the resident tripped and fell, was reviewed by the inspector. The same day the Morse Fall Scale rated the resident at a moderate risk for falls.

The initial assessment by a member of the multidisciplinary team, documented that the multi-disciplinary staff member's clinical impression was that the resident was at a moderate risk of falls. The Morse Falls Risk assessment from July 2015 was rated as a high risk for falls while on September 2015 was rated at a moderate risk for falls.

The DOC was interviewed and confirmed that the Falls Prevention and Management policy was correct and that the Morse Fall Scale Assessment was to be completed within 24 hours of admission and that this policy stated that if a resident was on more than five medications, the resident should be identified as a high risk for falls. The DOC confirmed that this was not done and that it should have been.

According to the licensee's Fall Prevention policy the assessments lacked compliance with timeliness and inclusion of required criteria.

The "Falls Prevention and Management" and "Resident Care Plan" policies required the resident to have been monitored for 48 hours after a fall for possible hematoma related to their anticoagulant therapy. The resident's care plans were reviewed and did not indicate that staff were to have monitored the resident for 48 hours after a fall for possible hematoma related to their anticoagulant therapy.

Consequently, the licensee has failed to ensure that the licensee's "Falls Prevention and Management" and "Resident Care Plan" policies have been complied with. [s. 8. (1)

(a),s. 8. (1) (b)]

***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 home's "Falls Prevention and Management" and "Resident Care Plan" policies are complied with, to be implemented voluntarily.***

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**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:**
**10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions including allergies, pain, risk of falls and other special needs.

The Point Click Care (PCC) system was reviewed for a resident which documented several diagnoses.

The Care Plans for the resident were reviewed.

The resident had diagnoses of complex medical conditions. The care plans did not include goals or interventions to manage the resident's complex medical conditions as well as the high risk for falls, increased risks post fall due to anticoagulant therapy and isolation precautions.

The Falls Prevention and Management policy stated that residents taking more than five medications were to be identified as high risk for falls and that residents taking anticoagulants and Aspirin (ASA) were to be monitored after a fall for possible hematoma. The physician orders identified the resident was ordered more than five medications on admission including ASA. An anticoagulant was initiated subsequently. The resident was on more than five medications prior to their fall.

The Daily Symptom Surveillance Form noted that on a particular day, the resident had vomiting twice. The care plan did not include a focus, goal or interventions related to the change in the resident's health condition and related to isolation initiated. The licensee Infection Control Isolation Care Plans (Contact and Droplet) policy required all residents to have their care plans updated to include all isolation precautions.

Consequently, the plan of care for the resident was not based on an interdisciplinary assessment with respect to the resident's health conditions. [s. 26. (3) 10.]

***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 plan of care for residents is based on an interdisciplinary assessment with respect to the resident's health conditions, to be implemented voluntarily.***

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**Issued on this 1st day of February, 2016**

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

**Original report signed by the inspector.**