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 prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Jul 15, 2016;	2016_428628_0003 (A1)	001646-16	Resident Quality Inspection

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) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Amended report with corrected dates

Issued on this 15 day of July 2016 (A1)

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

Original report signed by the inspector.

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

MARIE LAFRAMBOISE (628) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): February 8, 2016 to February 12, 2016 and from February 16, 2016 to February 19, 2016.

This inspection included complaints related to the relocation of resident within the home and a declined respite care complaint as well as critical incidents the home submitted related to alleged staff to resident abuse and a fall of a resident resulting in an injury which caused a significant change.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Chief Clinical Officer (CCO), Care Plan Coordinator, Restorative Care Staff Member, Director of Life Enrichment, Quality Representative, Registered Nurses (RN), Registered Practical Nurses (RPN,) Personal Support Workers (PSW), residents' family members and residents.

The inspector(s) conducted an inspection of common areas, observed the provision of care to residents, observed staff to resident interactions, reviewed various policies and procedures and reviewed clinical records, critical incident reports and employee personal files.

The following Inspection Protocols were used during this inspection:

Admission and Discharge

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **9 WN(s)**
- **5 VPC(s)**
- **3 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Inspector #612 observed resident #002 outside the nurses' station. The Inspector observed that the resident had an assistive device that was not applied properly.

The Inspector interviewed RPN #107 who confirmed that the assistive device should have been applied to the resident and they proceeded to apply the assistive device properly to the resident. The RPN stated that as per the written care plan, the resident was supposed to have a different assistive device and was unsure why they had a different assistive device.

The Inspector reviewed the resident's written plan of care which stated that the resident was to have had a specific assistive device while in their wheelchair.

The Inspector interviewed PSW #109 and #110. Both confirmed that the resident was at a high risk for a certain type of injury and that was why they required that specific assistive device. PSW #110 stated that the resident should have had another type of assistive device and was unsure why the resident did not have one available.

The Inspector interviewed RN #111 who confirmed that the care set out in the plan of care was not provided to resident #002 as specified in the plan. [s. 6. (7)]

2. A report was submitted to the Director regarding an incident of resident #008. According to the report, RPN #118 found resident #008 after they had sustained an injury. The resident received an injury and complained of pain. According to the report, a certain assistive device that the resident required had not been used.

A review of this resident's plan of care, in place at the time of the incident, revealed that resident #008 was at risk for certain injuries. The plan of care indicated that the resident required a specific assistive device to decrease the risk of injury.

The DOC stated in an interview that PSW #117 did not go into the room and check on the resident. They also confirmed that the assistive device had not been used as ordered by the physician. [s. 6. (7)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs changed or care set out in the plan was no longer necessary.

Inspector #612 observed that above resident #002's bed there was a sign that indicated that care should be given to the resident in a specific manner.

The Inspector reviewed resident #002's current care plan which indicated that the resident required care in a different manner. The Inspector reviewed a physiotherapy quarterly re-assessment form which stated that the resident required care in a specific manner. A review of the documentation in Point of Care revealed that in January 2016, the resident received care in a specific manner 96 percent of the time.

The Inspector interviewed PSW #109 and #110. They both stated that resident #002 required care in a specific manner however, on a bad day, which was rare the resident may have required care in a different manner. They reported that a couple months ago the resident had an injury and had required care in a different manner for a period of time.

The Inspector interviewed RPN #108 and RN #111 who confirmed that the care plan was not reviewed and revised when the resident's care needs changed or when the care set out in the plan was no longer necessary. [s. 6. (10) (b)]

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 LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, that clearly sets out what constitutes abuse and neglect.

The LTCHA Ontario Regulation 79/10 defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

As per the LTCHA, s. 96 every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected; contains procedures and interventions to deal with persons who have abused or neglected or allegedly abuse or neglected residents, as appropriate; identifies measures and strategies to prevent abuse and neglect; identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation: and identifies the training and retraining requirements for all staff, including, situations that may lead to abuse and neglect and how to avoid such situations.

The Inspector reviewed Finlandia Village policy titled, "Resident Abuse and Neglect - Zero Tolerance #Number ID-20" last revised July 2015.

The policy stated that, "If a resident who is the alleged perpetrator is not able to appreciate that their actions were wrong, it is not considered sexual abuse." The home is required to protect residents from abuse by anyone regardless of the perpetrator's cognitive status. The perpetrator's cognitive status does not determine whether sexual abuse, as defined in the Long-Term Care Homes Act (LTCHA), has occurred.

The policy does not contain current information for reporting alleged or suspected abuse incidents to the Director. The current policy referenced an unusual occurrence form that is outdated. [s. 20. (2)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007, 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 protect resident #004 and other residents from abuse by anyone.

On a specific date in 2016, Inspector #628 interviewed the family of resident #004 who indicated that they had concerns with the behaviour of resident #012. The family member indicated that resident #004 was found by staff on a specific date in 2015, in the bathroom of resident #012.

Sexual abuse is defined as per the Long Term Care Homes Act and Ontario Regulations 79/10 means, (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Review of resident #004's health care record by Inspector #628, indicated that resident #004 had a medical condition. The care plan for resident #004 encouraged a specific intervention.

Review of resident #012's health care record indicated a diagnosis of a medical

condition. Resident #012's care plan dated one month prior to the incident date indicated that they had inappropriate behaviour. The care plan goal was to have reduced inappropriate behaviours. Interventions were listed.

Progress notes for resident #012 revealed:
• During the month of their admission, it was documented that resident #012 was found in other residents' rooms where one unidentified resident was visibly scared.
• On the date of the specific incident, resident #012 was found in the bathroom with resident #004.
• Three days after the date of the first incident, resident #012 brought resident #004 into the dining room. Resident #012 touched resident #004 in a sexual nature. Resident #004 cried for several minutes. Staff separated the residents and after ten minutes, staff found resident #012 had taken resident #004 into the bathroom. The residents were separated. One-to-one staffing was provided for the shift. Staff documented that the event with resident #004 was not consensual.
• Nineteen days after the second incident, resident #012 was observed speaking to resident #004 in the dining room. Resident #004 was tearful.

In an interview with Inspector #628, the DOC confirmed the events involving resident #012 between four months in 2015 occurred as stated in the progress notes for resident #012.

As per the LTCHA, s. 20 (2)(b), the licensee without in any way restricting the generality of the duty provided for in section 19, shall ensure there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall clearly set out what constitutes abuse and neglect.

The Inspector reviewed Finlandia Village policy titled, "Resident Abuse and Neglect - Zero Tolerance #Number ID-20" last revised July 2015.

The home's policy stated that all residents are to be free from abuse and neglect. The policy stated that, "If a resident who is the alleged perpetrator is not able to appreciate that their actions were wrong, it is not considered sexual abuse." The home is required to protect residents from abuse by anyone regardless of the perpetrator's cognitive status.

In an interview with Inspector #628, the DOC confirmed the events involving resident #012 between the four months in 2015 occurred as stated in the progress notes for resident #012.

As per the LTCHA, s. 23(1)(a), every licensee of a long-term care home shall ensure that, every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated.

A review of the Finlandia Village policy titled, "Resident Abuse and Neglect - Zero Tolerance #Number ID-20" last revised July 2015 was completed. The policy required the Administrator/designate to conduct a thorough and confidential investigation that included completion of a Concern/Complaint Form and an Unusual Occurrence Form.

In an interview, the DOC confirmed that no formal home investigation was done of the events involving resident #012 and resident #004 that occurred in 2015.

As per the LTCHA, s. 24(1)(2), every licensee of a long-term care home shall ensure that, a person who has reasonable grounds to suspect that 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 has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

The DOC confirmed that no Critical Incident System (CIS) report regarding the events involving resident #012 and resident #004 that occurred 2015 was submitted to the Director. [s. 19. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 003

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident and their bed system were evaluated in accordance with evidence-based practices or in accordance with prevailing practices to minimize risk to the resident.

Inspector #612 observed resident #001, #002 and #003 in bed and noted they had bed rails in the guard position.

RN #102 confirmed in an interview that resident #001, #002 and #003 used bed rails.

The Inspector interviewed RN #111 who stated that there was no process to assess for bed rails; they would just trial different options to determine what was appropriate for the resident.

The Administrator and the DOC confirmed in an interview that the residents with bed rails were not assessed and their bed systems were not evaluated in accordance with evidence-based practices or in accordance with prevailing practices to minimize risk to the resident. [s. 15. (1) (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 where bed rails are used, the resident and their bed system is evaluated in accordance with evidence-based practices or in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated.

On a specific date in 2016, Inspector #628 interviewed the family of resident #004 who indicated that there had been concerns with resident #012. The family member indicated that resident #004 was found by staff on a specific date in 2015 in the bathroom of resident #012.

Progress notes for resident #012 revealed:
-During the month of admission, it was reported that resident #012 was found in three residents' beds where one unidentified resident was visibly scared.
-On the specific date of the incident, it was reported that resident #012 was found in the bathroom with resident #004.
-Three days after the date of the first incident, it was reported that resident #012 brought resident #004 into the dining room. Resident #012 touched resident #004 in a sexual nature. Resident #004 cried for several minutes.
-Nineteen days after the second incident, resident #012 was observed speaking to resident #004 in the dining room. Resident #004 was tearful.

A review of the Finlandia Village policy titled, "Resident Abuse and Neglect - Zero Tolerance #Number ID-20" last revised July 2015, indicated that, "all residents will be free from abuse and neglect by staff, volunteers, visitors and other residents. Each resident has the right to complain and be assured of a full and equitable investigation in the event of resident abuse. Any employee who witnesses, or becomes aware of, or suspects resident abuse or neglect shall report it immediately to the Administrator/designate who will conduct a thorough and confidential investigation."

In an interview, the DOC confirmed that no formal home investigation was done regarding any of the events involving resident #012 that were mentioned above. [s. 23. (1) (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 every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person, who had reasonable grounds to suspect that the abuse of a resident by anyone had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

On a specific date in 2016, Inspector #628 interviewed the family of resident #004 who indicated that there had been concerns with resident #012. The family member indicated that resident #004 was found by staff on a specific date in 2015 in the bathroom of resident #012.

Progress notes for resident #012 revealed:
-During the month of admission, it was reported that resident #012 was found in three residents' beds where one unidentified resident was visibly scared.
-On the specific date of the incident in 2015, it was reported that resident #012 was found in the bathroom with resident #004.
-Three days after the date of the specific incident, it was reported that resident #012 brought resident #004 into the dining room. Resident #012 touched resident #004 in a sexual nature. Resident #004 cried for several minutes.
-Nineteen days after the second incident, resident #012 was reported to have spoken to resident #004 in the dining room. Resident #004 was tearful.

A review of the policy titled, "Resident Abuse and Neglect - Zero Tolerance #Number ID-20" last revised July 2015, indicated that all residents are to be free from abuse and neglect. The policy required "any employee who witnesses, or becomes aware of, or suspects resident abuse or neglect shall report it immediately to the Administrator/designate who will conduct a thorough and confidential investigation." The policy required that the RN Charge Nurse would obtain information and notify the Ministry of Health and Long Term Care (MOHLTC) immediately if a resident was found to be abused or neglected that resulted in harm or risk of harm.

In an interview, the DOC confirmed that the Director was not immediately notified regarding the events involving resident #012 that occurred in 2015. [s. 24. (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 where 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: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids labelled within 48 hours of admission and of acquiring, in the case of new items.

During the initial tour of the home in February 2016, Inspector #612 observed the following:
• In the tub room on two home units there were unlabelled, used nail clippers left on the counter and on top of a storage box.
• In the tub room on another home unit there was a bottle of Neutrogena pore refining cream, not labelled and previously used.
• In the tub room on a different home unit there was an unlabelled white hair brush which had been used.

During the course of the inspection, Inspector #612 and #628 observed the following:
• The shared bathroom in a specific unit had a used hair brush that was not labelled and left out on the counter
• The shared bathroom in a specific unit had two used hair brushes that were not labelled, an unlabelled shampoo bottled and a personal care spray bottle that was not labelled and left out on the counter.
• The shared bathroom in a specific unit had a used hair brush and comb that were not labelled and left out on the counter.
• The shared bathroom in a specific unit had a used hair brush not labelled and left out on the counter.
• The shared bathroom in a specific unit had a toothbrush, nail clippers and toothpaste which had all been used and were not labelled and left out on the counter.

Inspector #612 interviewed PSW #112 and RPN #125 who stated that the nail clippers in the bathrooms are to be placed in the individual, labelled compartments of the storage box which are located in each unit's tub room. They stated that all resident's personal items, especially resident's with shared washrooms should have all their personal items such as brushes, combs, toothbrush, labelled.

The DOC confirmed in an interview that the nail clippers are not to be left out in the tub rooms; they are to be placed on the resident's compartment of the storage box. They also confirmed that the resident's personal belongings are to be labelled with the resident's name. [s. 37. (1) (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 each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart, that was used exclusively for drugs and drug-related supplies.

In February 2016, the Inspector observed on two separate home areas that medications were kept in the tub room. It was noted in one home area that prescription creams, ointments and shampoo from residents #013, #014 were found on a storage cart for personal care products. In another home area, prescription creams, ointments and shampoo for residents #015, #016, #017 and #018 were found on the personal care product storage cart stored in the tub room.

In February 2016, the Inspector observed on two separate home areas that medications were kept in the tub room. It was noted in one home area that prescription medications from resident #019, and on another home area prescription medications for resident #016 were kept on a storage cart.

The Inspector reviewed the home's Administration of Prescription Products by Unregulated Care Providers (UCP) policy #84, effective April 2016. According to the document, once the UCP has administered the product, the registered staff would ensure the product was stored in the medication room or locked in the medication cart when not in use.

In an interview with the Administrator they confirmed that no medications are to be kept in the tub rooms. They are to be stored in the medication cart or medication room. [s. 129. (1) (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 that drugs are stored in an area or a medication cart, that is used exclusively for drugs and drug-related supplies, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Inspector #612 reviewed resident #003's health care record and noted that the resident was incontinent, but that no assessment had been completed. The records did not include a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

The Inspector interviewed PSW #116 who confirmed that the resident was incontinent.

The Inspector interviewed RPN #115 who was unable to locate resident #003's incontinence assessment.

In February 2016, the DOC confirmed to the inspector that resident #003 had not been assessed using a clinically appropriate assessment instrument specifically designed for assessment of incontinence. [s. 51. (2) (a)]

Issued on this 15 day of July 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : MARIE LAFRAMBOISE (628) - (A1)

Inspection No. / No de l'inspection : 2016_428628_0003 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 001646-16 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Jul 15, 2016;(A1)

Licensee / Titulaire de permis : FINLANDIA NURSING HOME LIMITED
c/o Sudbury Finnish Rest Home, 233 Fourth Avenue, SUDBURY, ON, P3B-4C3

LTC Home / Foyer de SLD : FINLANDIA HOIVAKOTI NURSING HOME LIMITED
233 FOURTH AVENUE, SUDBURY, ON, P3B-4C3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Angela Harvey

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

To FINLANDIA NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall:

a) Perform an audit of all resident care plans to ensure that the care each resident requires is clearly outlined in the plan of care.

b) Develop and implement a process to audit compliance with ensuring that care is provided as specified in the plan.

c) Maintain a record of the audit, when it was completed, who completed it and what the results were. The home will maintain a record of what changes were made as a result of the audit and when these changes occurred.

d) Provide training to all staff involved in the direct care of residents. The training shall include but not be limited to: the importance of providing the care as specified in the plan and potential consequences to residents if not provided as specified in the plan.

d) Maintain a record of the required training of all staff involved in the care of residents, who completed the training, what the training entailed and when the training was completed.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out on the plan of care was provided to the resident as specified in the plan.

A report was submitted to the Director regarding an incident of resident #008. According to the report, RPN #118 found resident #008 after they had sustained an injury. The resident received an injury and complained of pain. According to the report, a certain assistive device that the resident required had not been used.

A review of this resident's plan of care, in place at the time of the incident, revealed that resident #008 was at risk for certain injuries. The plan of care indicated that the resident required a specific assistive device to decrease the risk of injury.

The DOC stated in an interview that PSW #117 did not go into the room and check on the resident. They also confirmed that the assistive device had not been used as ordered by the physician.
(543)

2. Inspector #612 observed resident #002 outside the nurses' station. The Inspector observed that the resident had an assistive device that was not applied properly.

The Inspector interviewed RPN #107 who confirmed that the assistive device should have been applied to the resident and they proceeded to apply the assistive device properly to the resident. The RPN stated that as per the written care plan, the resident was supposed to have a different assistive device and was unsure why they had a different assistive device.

The Inspector reviewed the resident's written plan of care which stated that the resident was to have had a specific assistive device while in their wheelchair.

The Inspector interviewed PSW #109 and #110. Both confirmed that the resident was at a high risk for a certain type of injury and that was why they required that specific assistive device. PSW #110 stated that the resident should have had another type of assistive device and was unsure why the resident did not have one available.

The Inspector interviewed RN #111 who confirmed that the care set out in the plan of care was not provided to resident #002 as specified in the plan.

(612)

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

Aug 19, 2016

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 # / 002 **Order Type /** Compliance Orders, s. 153. (1) (a)
Ordre no : **Genre d'ordre :**

Pursuant to / Aux termes de :

LTCHA, 2007, s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Order / Ordre :

The licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, that clearly sets out what constitutes abuse and neglect. 2007, c.8, s.20 (2)

(1) At a minimum, the reviewed and revised policy to promote zero tolerance of abuse and neglect of residents,

a) shall clearly set out what constitutes abuse and neglect; the licensee will review and revise the statement, "If a resident who is the alleged perpetrator is not able to appreciate their actions were wrong, it is not considered sexual abuse" to meet the definition in the LTCHA. The licensee will update the reference of submitting incidents to the Director, from an "unusual occurrence form" to the current incident reporting system.

(2) The licensee shall ensure that all staff are trained on the reviewed and revised policy to promote zero tolerance of abuse and neglect of residents and maintain a written documentation of the completed training. 2007, c.8, s.20(3).

Grounds / Motifs :

1. The licensee has failed to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, that clearly sets out what constitutes abuse and neglect.

The LTCHA Ontario Regulation 79/10 defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

As per the LTCHA, s. 96 every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected; contains procedures and interventions to deal with persons who have abused or neglected or allegedly abuse or neglected residents, as appropriate; identifies measures and strategies to prevent abuse and neglect; identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation: and identifies the training and retraining requirements for all staff, including, situations that may lead to abuse and neglect and how to avoid such situations.

The Inspector reviewed Finlandia Village policy titled, "Resident Abuse and Neglect - Zero Tolerance #Number ID-20" last revised July 2015.

The policy stated that, "If a resident who is the alleged perpetrator is not able to appreciate that their actions were wrong, it is not considered sexual abuse." The home is required to protect residents from abuse by anyone regardless of the perpetrator's cognitive status. The perpetrator's cognitive status does not determine whether sexual abuse, as defined in the Long-Term Care Homes Act (LTCHA), has occurred.

The policy does not contain current information for reporting alleged or suspected abuse incidents to the Director. The current policy referenced an unusual occurrence form that is outdated. (628)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

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

Aug 19, 2016

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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 shall ensure that resident #004 and all other residents are protected from abuse by anyone. Achieving compliance shall include, but not be limited to:

1-Developing a system to ensure the home's internal investigations related to every alleged, suspected or witnessed incident of abuse of a resident by anyone, is immediately and thoroughly investigated,

2-Developing and implementing a system to ensure that any allegation of abuse or neglect is reported to the Director immediately,

3-Reviewing and revising the policy to ensure it clearly sets out what constitutes abuse and neglect and that promotes zero tolerance of abuse and neglect of residents.

Grounds / Motifs :

(A1)
1. The licensee has failed to protect resident #004 and any other resident from abuse and neglect by anyone.

On February 10, 2016, Inspector #628 interviewed the family of resident #004 who indicated that they had concerns with the behaviour of resident #012. The family member indicated that resident #004 was found by staff on June 6, 2015, in the bathroom of resident #012. Both residents were undressed from the waist down.

Sexual abuse is defined as per the Long Term Care Homes Act and Ontario Regulations 79/10 means, (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Review of resident #004's health care record by Inspector #628, indicated that resident #004 had Dementia and mild cognitive impairment and resided in a secured home area. The care plan for resident #004 encouraged wandering on the unit.

Review of resident #012's health care record indicated a diagnosis of Alzheimer's disease with moderate to severe cognitive impairment. Resident #012's care plan (dated May 2015) indicated that they sought intimacy and or relationships by touching other residents inappropriately and had been found in bed with female residents. The care plan goal was to have "reduced incidents of inappropriate sexual behaviour." Interventions listed included but were not limited to:

-encouraging pet therapy,
-hand holding,
-to be monitored throughout the shift,
-redirect inappropriate behaviour and
-to turn on an infrared monitor (positioned at door) at bedtime.

Progress notes for resident #012 revealed:
• During the month of April 2015, it was documented that male resident #012 was found in three female residents' beds where one unidentified female resident was visibly scared.
• On June 6, 2015, resident #012 was found in the bathroom with female resident #004, both residents were undressed from their waist down.
• On June 9, 2015, resident #012 brought resident #004 into the dining room.

Resident #012 placed a hand on resident's #004's upper thigh. Resident #004 stated, "I do not like men, but I particularly do not like that man" and cried for several minutes. Staff separated the residents and after ten minutes, staff found resident #012 had taken resident #004 into the bathroom. The residents were separated. One-to-one staffing was provided for the shift. Staff documented that the event with resident #004 was not consensual.
• On June 28, 2015, resident #012 was observed speaking to resident #004 in the dining room. Resident #004 was tearful and stated to the staff member she "did not want that man".

In an interview with Inspector #628, the DOC confirmed the events involving resident #012 between April and July 2015 occurred as stated in the progress notes for resident #012.

As per the LTCHA, s. 20 (2)(b), the licensee without in any way restricting the generality of the duty provided for in section 19, shall ensure there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall clearly set out what constitutes abuse and neglect.

The Inspector reviewed Finlandia Village policy titled, "Resident Abuse and Neglect - Zero Tolerance #Number ID-20" last revised July 2015.

The home's policy stated that all residents are to be free from abuse and neglect. The policy stated that, "If a resident who is the alleged perpetrator is not able to appreciate that their actions were wrong, it is not considered sexual abuse." The home is required to protect residents from abuse by anyone regardless of the perpetrator's cognitive status.

In an interview with Inspector #628, the DOC confirmed the events involving resident #012 between April and July 2015 occurred as stated in the progress notes for resident #012.

As per the LTCHA, s. 23(1)(a), every licensee of a long-term care home shall ensure that, every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated.

A review of the Finlandia Village policy titled, "Resident Abuse and Neglect - Zero

Tolerance #Number ID-20" last revised July 2015 was completed. The policies required the Administrator/designate to conduct a thorough and confidential investigation that included completion of a Concern/Complaint Form and an Unusual Occurrence Form.

In an interview, the DOC confirmed that no formal home investigation was done of the events involving resident #012 and resident #004 that occurred on June 6 and June 9, 2015.

As per the LTCHA, s. 24(1)(2), every licensee of a long-term care home shall ensure that, a person who has reasonable grounds to suspect that 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 has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

The DOC confirmed that no Critical Incident System (CIS) report regarding the events involving resident #012 and resident #004 that occurred on June 6 and June 9, 2015 was submitted to the Director.

(628)

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

Aug 19, 2016

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 or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 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:

Health Services Appeal and Review Board and the Director

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 15 day of July 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MARIE LAFRAMBOISE - (A1)

Service Area Office /
Bureau régional de services : Sudbury