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 sous *la Loi de 2007 sur 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 # / No de registre	Type of Inspection / Genre d'inspection
Dec 20, 2018	2018_782736_0001	007300-18, 017613-18, 027222-18	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
233 Fourth Avenue SUDBURY ON P3B 4C3

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

AMANDA BELANGER (736), RYAN GOODMURPHY (638)

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): December 10-14, 2018.

The following intakes were inspected during this Critical Incident System (CIS) inspection:
-Two intakes related to critical incidents the home submitted to the Director related to a resident to resident physical abuse; and,
-One intake related to a critical incident the home submitted to the Director related to a fracture of unknown cause.

A Critical Incident Inspection #2018_786744_0001 was conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

The Inspector also conducted a daily tour of resident care areas, observed staff to resident interactions, reviewed relevant resident health care records, reviewed relevant internal investigation records, licensee policies, procedures, and programs.

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

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The Licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and information provided to the licensee or staff through observation that could have potentially triggered such altercations.

A Critical Incident Systems (CIS) report was submitted to the Director on a specified date, as a result of a resident to resident altercation that took place. Resident #001 and resident #003 were involved in an altercation and resident #001 sustained an injury.

Inspector #736 reviewed the progress notes on Point Click Care (PCC) for resident #001 and resident #003 and noted a total of five incidents over a three month period, where resident #001 and resident #003 demonstrated responsive behaviours towards each other as a result of resident #001 interacting with resident #003.

A review of resident #001's care plan, that was in place at the time of the incident on the specified date, indicated that a specific goal and a trigger related to responsive behaviours.

Inspector #736 reviewed resident #003's progress notes on PCC and noted on a specific date, a note, which indicated that resident #003 had increased responsive behaviours in the month of prior, all related to resident #001. In the interventions section of resident #003's care plan, it indicated a specific trigger. There was no indication in resident #003's care plan at the time of the incident, that resident #001 was a trigger for responsive behaviours for this resident. The Inspector reviewed further progress notes for resident #001 and #003 and noted incidents after the reported incident to the Director, of altercations that had taken place between the two residents on three further occasions in specified areas of the home.

In an interview with PSW #105, they identified to Inspector #736 that residents who had responsive behaviours would have their triggers identified in their care plan. PSW #105 further indicated that resident #001 and resident #003 were triggers for each other. They stated the specific responsive behaviour of resident #001and resident #003 when they interacted together.

In an interview with the Inspector, RPN #106 indicated that staff determined individual triggers for residents when they were able, and Registered Staff would have updated the resident's care plan so that all direct care staff had access to the resident's triggers. RPN #106 indicated that if a resident had four responsive behaviour episodes in a month related to a specific co-resident, that would be considered a trigger for the resident. When the Inspector asked how the home would have ensured that staff were aware of residents who trigger other residents to have responsive behaviours, RPN #106 indicated that the resident who was a trigger would be identified in the other resident's care plan. During the interview with the Inspector, RPN #106 indicated that resident #001 was a trigger for resident #003 to have responsive behaviours. RPN #106 confirmed that resident #001 and #003 primarily had previous altercations in one specified area of the home and there have been incidents of altercation between resident #001 and #003 in a different specified area of the home.

In an interview with Inspector #736, RN #107 indicated that if one resident was a trigger for another resident, it would be indicated on the resident's care plan. RN #107 also indicated that if two residents had five incidents of responsive behaviours over the course of three months, it would be considered a trigger. RN #107 confirmed that based on the progress note in resident #003's chart on the identified date, resident #001 should have been identified as a trigger on resident #003's care plan. RN #107 reviewed the care plans of resident #001 and #003 in effect at the time of the incident, and confirmed that neither residents were identified as a trigger for responsive behaviours for the other.

The home's policy titled "Prevention and Treatment of Responsive Behaviour –NM-S-9", last revised November 6, 2017, indicates that for residents demonstrating responsive behaviours, the triggers for the resident are identified in the plan of care. The policy also states that Registered Staff will analyze each incident to prevent further incidents in the future, including resident-resident interactions.

In an interview with Inspector #736, the DOC indicated that staff identified triggers for residents with responsive behaviours based on discussion with staff on the home area, monitoring and Dementia Observation System (DOS) charting. Based on the progress note on the specified date on resident #003's chart, the DOC indicated that both resident #001 and #003 should have been monitored when together. The DOC further stated that the behaviours that resident #001 displayed were a trigger for resident #003. The DOC confirmed that in regards to the incident of resident to resident altercation on the specified date, the home did not identify that resident #001 may have triggered resident #003 to have had responsive behaviours that would result in an altercation between the

residents. [s. 54. (a)]

Issued on this 21st day of December, 2018

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

Original report signed by the inspector.