

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

Sudbury Service Area Office
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965
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Original Public Report

Report Issue Date: November 29, 2022	
Inspection Number: 2022-1314-0002	
Inspection Type: Critical Incident System	
Licensee: Finlandia Nursing Home Limited	
Long Term Care Home and City: Finlandia Hoivakoti Nursing Home, Sudbury	
Lead Inspector Sylvie Byrnes (627)	Inspector Digital Signature
Additional Inspector(s) Inspector Samantha Fabiilli #000701 attended this inspection during orientation.	

INSPECTION SUMMARY

The Inspection occurred on the following date(s): November 21-25, 2022.

The following intake(s) were inspected:

- Two intakes related to resident to resident sexual abuse;
- Two intakes related to resident to resident physical abuse; and,
- Two intakes related to falls.

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

- Responsive Behaviours
- Falls Prevention and Management
- Infection Prevention and Control

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The licensee has failed to ensure that staff involved in the different aspects of care of a resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated, consistent with and complemented each other.

A resident's care plan indicated a specific intervention for the resident's call bell, however the resident's minimum data set (MDS) assessment indicated a different intervention. The resident was observed without the intervention listed on the care plan and the MDS. A PSW stated that the interventions listed in the resident's care plan and MDS were no longer required. The Director of Care (DOC) stated that they expected staff to bring forth discrepancies in the plan of care, and that the plan should identify the current care needs of the resident.

There was low risk to the resident regarding conflicting directives for the resident's call bell.

Sources: Observations; review of resident's care plan and MDS records, homes policy titled "Plan Of Care And Resident Care Plan" ; interviews with and DOC. [s. 6. (4) (b)]

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WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

1. The licensee has failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in their plan for the prevention and management of falls.

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A resident's current care plan indicated two interventions for the prevention of falls. On a specific date, the resident was observed in bed without the two interventions in place. A PSW confirmed that the resident should have had the two interventions in place.

There was moderate risk to the resident when they were not provided with the two fall prevention interventions.

Sources: Resident observation; record review of resident's care plan, homes policy titled "Plan of Care and Resident Care Plan"; interviews with a PSW and DOC [s. 6. (7)]

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WRITTEN NOTIFICATION: Policies and Records

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (1)

The licensee has failed to comply with the monitoring of a resident after they had an unwitnessed fall.

In accordance with O. reg 246/22 s. 53 (1) and s. 11 (1) (b), the licensee is required to ensure that there is a falls prevention and management program to reduce the incidence of falls and the risk of injury and must be complied with.

Staff did not comply with a policy which was included in the fall prevention and management program.

Monitoring was initiated after a resident had an unwitnessed fall. The monitoring was to occur at specific time intervals but was not completed for four consecutive assessments.

Sources: Home's policy titled, "Falls Prevention and Management"; interviews with three PSWs, two RNs and DOC.

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