Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
November 29, 30, and December 1, 2010	2010_158_2829_19Nov103338	Complaint IL-14502-SU # S-0298

Licensee/Titulaire

Finlandia Hoivakoti 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

Name of Inspector/Nom de l'inspecteur
Kelly-Jean Schienbein (158)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection related to locked doors in an unsecured unit of the home.

During the course of the inspection, the inspector spoke with:

- Administrator
- Director of Care (DOC)
- Assistant Director of Care (ADOC)
- RAI coordinator and back up coordinator
- Registered nursing staff (4 RN, 3 RPN)
- Personal Support Staff (8 PSW)
- Environmental Manager

During the course of the inspection, the inspector:

- Reviewed Colombe Bald health care record
- Reviewed the home's restraint policy
- Reviewed the home's Roam Alert policy
- Observed the Roam Alert functioning
- Observed care delivery provided to Colombe Bald by the PSW
- Interviewed front line staff, PSW's, housekeeping staff with regards to Colombe Bald care delivery
- Observed the staff's overall safety practices throughout the review

The following Inspection Protocols were used during this inspection:
Safe and Secure Home
Minimizing of Restraining
Personal Support Services

7 Findings of Non-Compliance were found during this inspection.
The following action was taken:
7 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with O Reg 79/10, s.91
Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labeled properly and are kept inaccessible to the residents at all times.

Findings:

- Inspector 158 observed on November 30, 2010 that the housekeeping/janitor's closet door on Koivu unit was propped opened and unattended..
- Virox and various caustic cleaning solutions were observed in this closet and accessible to the residents.
- Hazardous substances were not kept inaccessible to the residents.

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WN #2: The Licensee has failed to comply with LTCHA 2007, c.8, s. 30(1) 5
Every licensee of a long-term care home shall ensure that no resident of the home is:
Restrained by the use of barriers, locks, or by other devices or controls from leaving a room or any part of the home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36

Findings:

- The health care record of a resident was reviewed by inspector 158 on November 30, 2010.
- These records identified that the resident was starting to exhibit escalating elopement behaviour from one unit.
- The documentation identified that the doors to this unit as well as the adjacent unit were locked via keypad for three consecutive days.
- The DOC and ADOC confirmed during the interview with inspector 158 on November 30, 2010, that a locked environment was created when the doors to the two units were key padded locked to prevent this resident from leaving the home.
- It was confirmed by the ADOC that an assessment or re-assessment of the resident's condition and the effectiveness of a restraint was not completed when the doors were locked. It was also confirmed that a doctor's order was not obtained.
- The home's policy NM-S-10 titled "Restraint and PSAD's Physical, Chemical and Environmental" was reviewed on November 30, 2010 by the inspector. It stated "Environmental restraints create barriers to a resident's freedom to move for the purpose of confining that resident to the geographical area or space of the home."
- The resident was restrained in a locked unit for three consecutive days.

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WN # 3: : The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 31(2) 1
The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.

4. A physician has ordered or approved the restraining

Findings:

- A resident's care plan was reviewed on November 30, 2010. The care plan identified that the resident will wander into other resident's beds. It did not identify the significant risk of the resident exit seeking or the past elopement and wandering in the parking lot of the home.
- As well, a physician's order for restraining the resident by locking the unit's doors was not found in the resident's health care record.
- The resident's plan of care did not include the significant risk of exit seeking and elopement and the physician's order for the restraint.

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WN # 4: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 6(1)(c)
Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out clear direction to staff and others who provide direct care to the resident.

Findings:

- The resident's care plan was reviewed by inspector 158 on November 30, 2010. The care plan identified that the she will wander into other resident's beds.
- It did not identify that the resident exit seeks when wandering or that the resident will leave the building if not prevented.
- The care plan does not set out clear direction to staff or others providing direct care to the resident regarding the management of the resident's exit seeking behaviour.

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WN # 5: The Licensee has failed to comply with LTCHA 2007, c. s. 5
Every resident has the right to live in a safe and clean environment.

Findings:

- The inspector observed the servery door that connects the locked "dementia" unit's dining/common room to the front foyer of the home was opened and unsupervised on November 29, 2010.
- The inspector observed three dementia unit residents wander toward this open door located in the dining/common room. Supervision by staff of the three residents was not observed.
- The three residents were redirected away from the open door by the inspector.

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WN # 6: The Licensee has failed to comply with O Reg 79/10, s. 87(2)(d)
As part of the organized program of housekeeping, the licensee shall ensure that procedures are developed and implemented for:
Addressing incidents of lingering offensive odours

Findings:

- A urine odour was detected in one room on November 29, 2010 by inspector 158. This was discussed with the Environmental manager. The urine smell was still prevalent in this room and in the hallway on November 30, 2010.
- The home did not address the incident of lingering odours.

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WN # 7: The Licensee has failed to comply with LTCHA 2007, c.8, 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 of care.

Findings:

- In a resident's care plan under fall prevention, it stated "wander guard to right ankle".
- However, a "Roam Alert" bracelet was observed by the inspector on November 30/10 to be used on the resident's wheel chair.
- The environmental manager confirmed on November 30, 2010 that the bracelet was an intervention to manage this resident's exit seeking behaviour.
- The care set out in the plan of care was not the care provided to the resident.

Inspector ID #:	158

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Kchuenken Aug 3/11
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).