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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 31, 2013	2013_140158_0009	1392-12-0103-13, 0153-13,	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

KELLY-JEAN SCHIENBEIN (158)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 9 and 10, 2013

Logs # S-000994-12, S-000995-12, S-000996-12, S-001392-12, S-000036-13, S-000113-13, and S-000153-13 were reviewed.

During the course of the inspection, the inspector(s) spoke with Administrator, the Director of Care (DOC), the Life and Enrichment Manager, Registered Nursing Staff (RN/RPN), Personal Support Workers (PSW), families and residents

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas,reviewed resident health care records, reviewed various resident care policies, and observed resident care delivery by staff

The following Inspection Protocols were used during this inspection:
Dining Observation

Falls Prevention

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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).

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).

Findings/Faits saillants :

1. The licensee did not ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.
A Critical Incident was reported to the Director identifying that resident # 03 had a fall in April 2013 and sustained an injury.
The home completed a post fall assessment and fall risk assessment which identified the resident as a high risk to fall. However, these assessments did not include an assessment of the resident's gait or balance by the physiotherapist, as per the home's policy titled "Falls Prevention and Management".
Three members of the Falls committee were interviewed and identified that all falls are reviewed at the monthly meetings but they were not aware of any assessment of the resident's gait and balance conducted by the physiotherapist.
Although there was documentation found in resident # 03 progress notes related to the fall, an assessment of resident's balance and gait by the physiotherapist was not found.
Staff and others involved in the different aspects of care of resident # 03 did not collaborate with each other in the assessment when resident # 03 fell. [s. 6. (4) (a)]

2. The licensee did not ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.
A Critical Incident was reported to the Director identifying that resident # 04 was found on the floor in December 2012 after getting out of the wheel chair and attempting to walk. Resident # 04 sustained an injury.
The home completed a post fall assessment and fall risk assessment which identified the resident as a high risk to fall. However, these assessments did not include an assessment of the resident's gait or balance by the physiotherapist, as per the home's policy titled "Falls Prevention and Management".
Three members of the Falls committee were interviewed and identified that all falls are reviewed at the monthly meetings but they were not aware of any assessment of the resident's gait and balance conducted by the physiotherapist.
Resident # 04 progress notes were reviewed by the Inspector and although there was documentation related to falls found under nursing rehabilitation and under falls with and without injury, an assessment of resident's balance and gait by the physiotherapist was not found.
Staff and others involved in the different aspects of care of resident # 04 did not collaborate with each other in the assessment when resident # 04 fell. [s. 6. (4) (a)]

3. The licensee did not ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.
A Critical Incident was reported to the Director identifying that resident # 02 who has a history of self transferring fell in January 2013. Resident # 02 sustained an injury and had difficulty weight bearing.
The home did complete a post fall assessment and fall risk assessment in January 2013, which identified the resident as a high risk to fall. However, these assessments did not include an assessment of the resident's gait or balance by the physiotherapist, as per the home's policy titled "Falls Prevention and Management".
Three members of the Falls committee were interviewed and identified that all falls are reviewed at the monthly meetings but they were not aware of any assessment of the resident's gait and balance conducted by physio.
Although there was documentation found in the progress notes under nursing rehabilitation and under falls with and without injury, an assessment of resident's balance and gait by the physiotherapist was not found.
Staff and others involved in the different aspects of care of resident # 02 did not collaborate with each other in the assessment when resident # 02 fell. [s. 6. (4) (a)]

4. A critical incident was reported in April 2013 identifying that resident # 01 sustained an injury when the hot soup spilled on the resident's lower body while they were eating.
The inspector observed the resident eating three meals on May 9 and May 10, 2013. The resident was sitting in the w/c and the resident's body was leaning to the left. The Inspector observed that the resident spilled food and fluids as they ate. Resident # 01 care plan identifies that the resident requires intermittent encouragement and supervision with eating. As well, the care plan identifies that the side arm of the resident's w/c be flipped out of the way to ensure that the resident is sitting close to the table. Inspector noted that for all meals observed, the side arm of the wheel chair was in place and not flipped out of the way creating a four inch (approx) distance from wheel chair and the table. The care set out in the plan of care was not provided and did not ensure that resident # 01 was sitting close to the table. [s. 6. (7)]

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 ensuring that staff and others involved in the different aspects of care for resident # 02, #03 # 04 collaborate with each other in the fall risk assessment so that their assessments are integrated and that the care set out in the plan of care is provided to resident # 01, as specified in the plan, specifically related to the wheelchair at meal services, to be implemented voluntarily.

Issued on this 31st day of May, 2013

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