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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 13, 2016	2016_395613_0010	008154-15, 005816-15, 001744-15, 009914-14, 005232-14, 005134-14	Critical Incident System

Licensee/Titulaire de permis

THE ONTARIO-FINNISH RESTHOME ASSOCIATION
725 North Street Sault Ste Marie ON P6B 5Z3

Long-Term Care Home/Foyer de soins de longue durée

MAUNO KAIHLA KOTI
723 North Street Sault Ste Marie ON P6B 6G8

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

LISA MOORE (613)

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): May 30 - June 3, 2016

This Critical Incident Inspection is related to the following:

One critical incident the home submitted related to plan of care interventions regarding a resident fall, and

Five critical incidents the home submitted that were not amended as requested by the Director.

During the course of the inspection, the inspector(s) spoke with the Executive Director of Care and a Registered Practical Nurse.

During the course of the inspection, the Inspector conducted a walk through of the home, observed staff to resident interactions and reviewed health care records and various policies and procedures of the home.

A concurrent Complaint Inspection #2016_395613_0008 and Follow up Inspection #2016_395613_0009 were also conducted during this inspection.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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	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.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that that the results of every investigation undertaken under clause (1) (a) and every action taken under clause (1) (b) was reported to the Director.

Inspector #613 reviewed a Critical Incident Report (CI) that was submitted to the Director by the licensee. The Director had requested the licensee to amend the CI to identify the results and actions taken by the home.

A review of the CI identified that resident #006 abused resident #007, resulting in an altercation and injury to both residents' arms. The licensee submitted the CI to the Director in December 2014 and four days later, the Director requested the licensee to amend the CI regarding finalized actions in place for resident #006 and if resident #007's family was satisfied with the home's resolution. An amendment from the licensee was not provided to the Director as of May 18, 2016.

During an interview on June 2, 2016, with the Executive Director of Care (EDOC), they confirmed to the Inspector that the CI had not been amended as requested by the Director and it should have been. The EDOC was unaware that email notifications had been sent from the Director requesting an amendment on the CI report. [s. 23. (2)]

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 they report to the Director the results of every investigation undertaken and every action taken. As well, perform daily checks of email notifications and amend Critical Incident Reports in a prompt manner, as requested by the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure they informed the Director of an incident under subsection (1), (3) or (3.1) within 10 days of becoming aware of the incident, or sooner if required by the Director to make a report in writing to the Director setting out the names of any residents involved in the incident.

Inspector #613 reviewed a Critical Incident Report (CI) that was submitted to the Director by the licensee. The Director had requested the licensee to amend the CI.

A review of the CI identified that an upper respiratory infection outbreak had been declared by the Public Health Unit on April 9, 2015 and was reported to the Director on the same date. On April 10, 2015, the Director requested the licensee to amend the CI of any new cases/deaths related to the outbreak indicating the resident's names on line list and declare when the outbreak was over. An amendment from the licensee was not

provided to the Director as of May 18, 2016.

During an interview on June 2, 2016, with the Executive Director of Care (EDOC), they confirmed to the Inspector that the CI had not been amended as requested by the Director and it should have been. The EDOC was unaware that email notifications had been sent from the Director requesting an amendment on the CI report. [s. 107. (4) 2. i.]

2. The licensee has failed to ensure they informed the Director of an incident under subsection (1), (3) or (3.1) within 10 days of becoming aware of the incident, or sooner if required by the Director to make a report in writing to the Director setting out the immediate actions that had been taken to prevent recurrence.

Inspector #613 reviewed three Critical Incident Reports (CI) that were submitted to the Director by the licensee. The Director had requested the licensee to amend all three CI's to identify the health status of the resident upon return to the home and the plans in place to prevent recurrence.

A) A review of a CI identified that resident #003 had a fall and was found sitting on the floor in a room. As a result of the fall, resident #003 was transferred to the hospital and sustained an injury. The licensee submitted the CI to the Director in September 2014 and seven days later, the Director requested the licensee to amend the CI with specific details of resident #003's care needs and actions taken to prevent recurrence. An amendment from the licensee was not provided to the Director as of May 18, 2016.

B) A review of a CI identified that resident #004 had a fall and was found lying on the floor on a unit. As a result of the fall, resident #004 was transferred to the hospital and sustained an injury. The licensee submitted the CI to the Director in September 2014 and one day later, the Director requested further information from the licensee to amend the CI with specific details of resident #004's health status and actions taken to prevent recurrence. An amendment from the licensee was not provided to the Director as of May 18, 2016.

C) A review of a CI identified that resident #005 had a fall and was found lying on the floor in a room. As a result of the fall, resident #005 was transferred to the hospital and sustained an injury. The licensee submitted the CI to the Director in December 2014 and nine days later, the Director requested the licensee to amend the CI with specific details of resident #005's care needs prior and post the fall and actions taken to prevent recurrence. An amendment from the licensee was not provided to the Director as of May

18, 2016.

During an interview on June 2, 2016, with the Executive Director of Care (EDOC), they confirmed to the Inspector that all three CI's had not been amended as requested by the Director and they should have been. The EDOC was unaware that email notifications had been sent from the Director requesting an amendment on the CI reports. [s. 107. (4) 4. i.]

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 they inform the Director of an incident under subsection (1), (3) or (3.1) within 10 days of becoming aware of the incident, or sooner if required by the Director to make a report in writing to the director setting out the names of any residents involved in the incident and immediate actions that have been taken to prevent recurrence. As well, perform daily checks of email notifications and amend Critical Incident Reports in a prompt manner, as requested by the Director, to be implemented voluntarily.

Issued on this 15th day of June, 2016

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

Original report signed by the inspector.