



**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  
prévus le Loi de 2007 les  
foyers de soins de longue**

**Health System Accountability and Performance  
Division**

**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la  
performance du système de santé**

**Direction de l'amélioration de la performance et de la  
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Public Copy/Copie du public

| Date(s) of inspection/Date(s) de l'inspection | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|-----------------------------------------------|-----------------------------------|---------------------------------------|
| Feb 14, 16, 17, May 21, 22, 2012              | 2012_104196_0005                  | Complaint                             |

**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**

LAUREN TENHUNEN (196)

**Inspection Summary/Résumé de l'inspection**

The purpose of this inspection was to conduct a Complaint inspection.

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

During the course of the inspection, the inspector(s) conducted a tour of the home, observed the provision of care and services to residents, reviewed the resident's health care record, reviewed a letter of complaint that was sent to the home and the letter of response that was sent to the complainant and forwarded to the Ministry of Health and Long-Term Care (MOHLTC).

The following Inspection Protocols were used during this inspection:

Personal Support Services

Findings of Non-Compliance were found during this inspection.

**NON-COMPLIANCE / NON-RESPECT DES EXIGENCES**

| Legend                                                                                                                                                                                                                                                                  | Legende                                                                                                                                                                                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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 subsections:**

**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. According to a letter of complaint received by the home and forwarded to the MOHLTC, a resident experienced a fall during a transfer while being assisted by a staff member. Inspector reviewed the health care record for resident #001. The care plan identified that the resident required a one person assist with a transfer belt for transferring from one position to another. A staff member assisted the resident with a transfer on November 6, 2011 and did not use a transfer belt and the resident sustained a fall. The resident's care plan for transferring was not followed by the staff member. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [LTCHA 2007, S.O. 2007, c. 8, 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 that ensures that the care set out in the plan of care is provided to all residents as specified in their plan, to be implemented voluntarily.***

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. According to a letter of complaint received by the home and forwarded to the MOHLTC, a resident experienced a fall during a transfer while being assisted by a staff member. It was identified that the staff member did not use a transfer belt as is included in the resident's plan of care and the resident sustained a fall on November 6, 2011. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents. [O. Reg. 79/10, s. 36.]



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Issued on this 22nd day of May, 2012

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

 #196