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
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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
Dec 9, 2015	2015_340566_0018	033033-15	Resident Quality Inspection

Licensee/Titulaire de permis

TORONTO FINNISH-CANADIAN SENIORS CENTRE
795 EGLINTON AVENUE EAST TORONTO ON M4G 4E4

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

SUOMI-KOTI TORONTO NURSING HOME
795 EGLINTON AVENUE EAST TORONTO ON M4G 4E4

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

ARIEL JONES (566), JUDITH HART (513), TIINA TRALMAN (162)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 30, December 1, 2, 3, 4, 7 and 8, 2015.

During the course of the inspection, the inspector(s) spoke with the director of care (DOC)/Administrator, RAI-Coordinator, registered nursing staff, personal support workers (PSW), dietary aides, activity aid, volunteers, residents and family members.

During the course of the inspection, the inspectors toured the home, observed resident care, observed meal service, reviewed resident health records, meeting minutes, schedules, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Residents' Council
Responsive Behaviours

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with that Act.

On December 7, 2015, during medication administration, the inspector observed that medications were removed from their pouches and that the corner of the medication pouch containing the resident's name was torn and placed in a cup for destruction. The remainder of the pouch, which included the resident's room number, date and time for medication administration, medication name, prescription number and quantity, were placed in a bin on the side of the medication cart for removal to the general garbage. The above stated information, which was intact and visible on the discarded pouch, is part of the residents' personal health information (PHI).

An interview with registered staff #102 revealed that he/she was not aware that the room number could be traced back to the resident, therefore revealing personal health information (PHI).

An interview with the DOC confirmed that a resident's room number and medication prescription was part of their PHI and should be destroyed. [s. 3. (1) 11. iv.]

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 the residents' right to have his/her personal health information, within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with that Act, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care is based on an interdisciplinary assessment of the resident that includes: any mood and behaviour patterns, any identified responsive behaviours, and any potential behavioural triggers and variations in resident functioning at different times of the day.

A review of the minimum data set (MDS) resident assessment instrument (RAI) and resident assessment protocol (RAP) from an identified date in September 2015, revealed that resident #012 has responsive behaviours. Interviews with PSWs #103 and #110 and registered staff #102, as well as a review of the progress notes between identified dates in July to November 2015, revealed that the resident exhibited identified responsive behaviours on multiple occasions during this time period.

A review of the resident's health care record revealed that a written plan of care was not developed based on the above assessments. An interview with registered staff #102 confirmed that a responsive behavior plan of care had not been developed and implemented for resident #012.

An interview with the DOC confirmed that a written care plan should have been developed for resident #012's responsive behaviours along with corresponding interventions. [s. 26. (3) 5.]

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 the responsive behaviour plan of care for all residents with behaviours is based on an interdisciplinary assessment of the resident that includes: any mood and behaviour patterns, any identified responsive behaviours, and any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

Issued on this 9th day of December, 2015

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

Original report signed by the inspector.