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 # / No de registre	Type of Inspection / Genre d'inspection
Nov 29, 2017	2017_687607_0020	023193-17	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

JULIET MANDERSON-GRAY (607), JENNIFER BATTEN (672)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 20, 21, 22, 23, 24, 25 and 27, 2017

The following Intake Log was inspected concurrently with the Resident Quality Inspection
1) Log # 024431-17, regarding an incident that caused injury to a resident for which the resident was taken to hospital.

During the course of the inspection, the inspector(s) spoke with the Administrator (ADM), Director of Care (DOC), Food and Service Manager (FSM), Housekeeping and Maintenance Manager (ESM), Housekeeping Supervisor (HSKS), Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), the Presidents to Resident and Family Council, family members and residents.

During the course of the inspection, the inspector(s) conducted a tour of resident home areas, observed staff to resident interactions and provision of care, medication administration, reviewed relevant home records, relevant policy and procedures, and resident health records

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **6 WN(s)**
- **3 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Related to Log #024431-17 involving resident #021:

A Critical Incident Report was submitted to the Director on an identified date for an incident that occurred on an identified date and time, that caused an injury to resident #021 for which the resident was taken to hospital.

A review of the clinical health records for resident #021 indicated there were several interventions in place related to falls and transfer, including remind resident #021 to use an identified mobility aid as well as the resident use a specific transfer device with the assistance of two staff.

During an observations on an identified date and time, Inspector #607, observed two transfer symbols located in an identified area of resident's #021's personal space. One of the symbol, indicated that the resident required the use of a specific transfer device and

the other indicated the resident required a two person assist without a device for transfers. Resident #021 was also observed to be locomoting around the unit with use of an identified mobility device.

During an interview, by Inspector #607, Personal Support Worker (PSW) #112 indicated that resident #021 was being transferred with the use of two staff and no longer transferred with the use of an assisstive device. PSW #112 also indicated that resident #021 no longer used a specific device for ambulation since his/her last injury two months prior.

During an interview, Registered Nurse (RN) #103 indicated that resident #021 required a two person transfer and no longer ambulated with the use of an identified assisstive device. RN #103 further indicated that the written plan of care was not updated to include the resident’s current transfer status which was changed since one month prior.

During an interview, the Director of Care (DOC) indicated that resident #021's written plan of care was not updated to include the resident's current transfer status or that the resident no longer required the use of a specific device. The DOC further indicated the plan of care did not provide clear direction and the expectation is all registered staff are responsible for updating the written plan of care.

The licensee failed to ensure resident #021's written plan of care set out clear directions to staff and others who provide direct care to the resident, specifically related to the care plan indicated that the resident uses a specific device to assist with ambulating when the resident uses another identified assisstive device, as well as the transfer logos located in an identified area indicated the resident is being transferred with both an identified transfer device as well as without the device . [s. 6. (1) (c)]

2. The licensee has failed to ensure that when a resident is reassessed and the plan of care is reviewed and revised at any other time when the resident's care needs change or when the care set out in the plan is no longer necessary.

Related to Log #024431-17 involving resident #021:

A Critical Incident Report was submitted to the Director on an identified date, for an incident that occurred on an identified date, that caused injury to resident #021 for which the resident was taken to hospital.

A review of the clinical health record for resident #021 indicated the following interventions were in place related to transfers: Keep an identified body part secure at all times with an identified support device.

During an observation on an identified date, Inspector #607, observed resident #021 ambulating without the use of the identified support device to the resident's body part.

During an interview, with Inspector #607, PSW #112 indicated that resident #021 no longer uses a support to his/her body part.

During an interview,with Inspector #607, the Director of Care who is also a Registered Nurse on the unit, indicated that resident #021 no longer uses the support to his/her body part and further indicated the resident's current written plan of care was not updated to reflect this.

The licensee failed to ensure that when resident #021 was reassessed, the plan of care was reviewed and revised at any other time when the resident's care needs change or when the care set out in the plan was no longer necessary, specifically related to the written care plan indicated the resident uses an identified support device to an identified body part, when the resident no longer used the support. [s. 6. (10) (b)]

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 the plan of care set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept locked to restrict unsupervised access to those areas by residents.

On an identified date, during the initial tour of the home, Inspector #672 observed that the spa room door had a coded panel lock on the door. The Inspector was able to push the door open, without entering a code. Upon entering the spa room, the Inspector noted that two spray bottles were located on a wooden shelf, one was labelled as "Emerald Dust bane Cleanser" and the second spray bottle was labelled as "Virox 256". Inspector #672 also noted a large bag on one of the care carts, which had three tubes of medicated lotions inside.

During an interview on an identified date, PSW #101 indicated that the medicated creams should not have been left in the shower room, as the expectation of the non-registered staff is that all medicated creams are to be returned to the registered staff immediately following administration. PSW #101 indicated that the creams had accidentally been left behind in the shower room, following a resident shower that morning, and further indicated the medicated creams were to be immediately returned to RN #103. PSW #101 further indicated that the door to the spa room was supposed to be kept closed and locked at all times.

During an interview on an identified date, Housekeeping Supervisor (HSKS) #110 indicated that the contents of both spray bottles located on the shelf in the spa room were chemicals used for cleaning and disinfecting the shower, and other high touch areas. HSKS #110 further indicated that cleaning chemicals were to be kept behind locked doors, and out of residents' reach at all times.

On an identified date, during the initial tour of the home, Inspector #672 observed that

the soiled utility room door had a coded panel lock, but the Inspector #672 was able to push the door open, without entering a code into the door. Upon entering the soiled utility room, Inspector #672 observed that in the first cupboard there was a large hammer located on the bottom shelf, along with multiple sharps containers. There was also an "Arjo Tornado" cleaning machine, with cleaning chemicals present, and on top of the machine were stacked slipper pans and urinals, all soiled and noted to have been previously used.

During an interview on an identified date, RN #103 indicated the expectation is that the door to the spa room and the soiled utility room were to be kept closed and locked at all times, to prevent resident access to those areas. RN #103 further indicated that non-registered staff are expected to return the medicated creams to the RN or RPN on duty, immediately following application of the creams after residents care.

On another identified date and time Inspector #672 was able to push the door to the spa room open, without entering a code into the door. Upon entering the spa room on this date, Inspector #672 observed the same two spray bottles located on a wooden shelf, one was labelled as "Emerald Dust bane Cleanser" and the second spray bottle was labelled as "Virox 256", along with open jars of “Infazinc”, "Health Care White Petroleum Jelly", "Be Fresh" mouth wash, one tube of Aim toothpaste, and one canister of "Gillette" shaving cream, all located on one of the three care carts which were parked in the spa room for storage. Inspector #672 then walked across the hall to the soiled utility room, and observed that the door to the soiled utility room was also able to be pushed open, without entering a code into the door. Upon entering the soiled utility room, all of the same items remained, as was observed on the afternoon of that same day.

During an interview on an identified date, RN #103 indicated the expectation is that the door to the spa room and the soiled utility room were to be kept closed and locked at all times, to prevent resident access to those areas while unsupervised.

During an interview on an identified date, DOC #111 indicated the expectation is that all doors leading to areas not accessible to residents were to be kept closed and locked at all times, to restrict unsupervised access to those areas by residents.

The licensee failed to ensure that all doors leading to areas accessible to staff only were kept locked to restrict unsupervised access to those areas by residents, specifically related to the spa room and the soiled utility room. [s. 9. (1) 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 ensuring that all doors leading to non-residential areas were kept locked to restrict unsupervised access to those areas by residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident had their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission, and in the case of new items, of acquiring.

On an identified date, during the initial tour of the home, Inspector #672 noted the following in the shower room:

- There were three care carts stored in the shower room. Each cart had unlabelled jars of "Health Care White Petroleum Jelly" and "Infazinc" on the top shelf, and had been used, as each jar was between 75 percent, to almost empty. There were also noted unlabelled bottles of "Natura" body lotion, which were between being almost full to 75 percent empty. One of the carts also had one blue, disposable razor on it, which noted to have been used, and did not have a resident's name on it.

- There was a wooden shelf above the tub, which also had an unlabelled jar of "Health

Care White Petroleum Jelly", which was 75 percent empty, an unlabelled jar of "Infazinc" zinc oxide which was half empty, one bottle of "Be Fresh" mouth wash, which was unlabelled and half empty, one tube of unlabelled Aim toothpaste, which had been opened and used, one canister of unlabelled "Gillette" shaving cream, which felt to be almost empty when shaken by the Inspector.

On identified date, Inspector #672 made the following observations:

- In six identified shared bathroom of rooms, there were an unlabelled tooth brush on the sinks, and under the sink there were unlabelled wash basins, an unlabelled urinals, an unlabelled urine collection "hats", an unlabelled slipper pans and an unlabelled black comb on the counter top.

During an interview, PSW #100 indicated that the items stored in the shower room were used communally, if the resident was receiving a shower, and the staff member had forgotten to bring the residents' personal products to the shower room, the products stored in the shower room were used, to assist in saving time. PSW #100 further indicated that the expectation of the nursing team was to ensure that each resident had their own, labelled personal care items, and those items were to be used only on the resident they belonged to.

During an interview, PSW #101 indicated that the unlabelled personal care items noted in the shared resident bathrooms should be labelled with the residents' name, and should only be used for that resident. PSW #101 was unable to state which resident the items were assigned to in any of the bathrooms where they were located, stated that the staff tried to keep the items located on a specific side of the bathroom for each resident, but indicated that if the items were accidentally mixed up, it would not be possible to tell which item belonged to each resident.

Inspector #672 interviewed DOC #111 who indicated that the expectation of the nursing team was to ensure that all personal items were labelled with the residents' name, and the items were only to be used by the resident the item belonged to.

The licensee failed to ensure that each resident had their personal items, including personal aids, labelled within 48 hours of admission, and in the case of new items, of acquiring. [s. 37. (1) (a)]

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 each resident had their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission, and in the case of new items, of acquiring, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Record review indicated that one identified concern was brought forward related food services and portion size; and another related to the nursing department and resident care during the Residents' Council meeting on an identified date.

Record review also indicated that one identified concern related to residents being taken to dining room too early as well as another related to housekeeping and residents washrooms/toilet seats were not being kept clean, were brought forward during another Residents' Council meeting on an identified date two months later.

The written response from the Administrator regarding the first Residents' Council meeting, did not address the concerns brought forward related to the resident's care and portion size.

The written response from the Director of Care (DOC) that was held two months later, only addressed the concerns brought forward related dining room service and portion size, but did not address the concerns brought forward during the second Residents' Council meeting related to housekeeping and residents washrooms not being kept clean.

During interview with the DOC, by Inspector #607, indicated that written responses were not provided to these concerns within the designated 10 day time frame. [s. 57. (2)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure to seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

During an interview with the President of the Family Council indicated that the home did not consult with the Family Council when the questions of the satisfaction survey were being developed. The President indicated that he/she was not aware of the satisfaction survey.

During an interview with Administrator indicated that the licensee expectation is that the advice of Family Council be sought in developing and carrying out of the satisfaction survey. [s. 85. (3)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all medications were stored in an area or a medication cart, which was used exclusively for drugs and drug-related supplies, and was secure and locked.

On an identified date, during the initial tour of the home, Inspector #672 observed that the spa room door had a coded panel lock, but the Inspector #672 was able to push the door open, without entering a code into the door. Upon entering the spa room, the Inspector noted that a large bag was sitting on one of the care carts which was stored within the room, and had three tubes of medicated creams inside.

During an interview, PSW #101 indicated that the medicated creams should not have been left in the spa room, as the expectation of the non-registered staff was that all medicated creams were to be returned to the registered staff immediately following administration of the creams. PSW #101 further indicated that the medicated creams had accidentally been left behind in the spa room, following a resident shower earlier that morning. The medicated creams were immediately returned to RN #103, following the interview with PSW #101.

During an interview, RN #103 indicated the expectation was that non-registered staff were to return the medicated creams to the RN or RPN on duty, immediately following application of the creams during resident care, and were not to be stored in resident rooms or areas accessible to staff only, at any time.

During an interview, DOC #111 indicated that non-registered staff were expected to return the medicated creams to the registered staff on duty, immediately following application of the creams during resident care, and were not to be stored in resident rooms or areas that were suppose to be accessible to staff only, at any time.

The licensee has failed to ensure that all medications were stored in an area or a medication cart, which was used exclusively for drugs and drug-related supplies, and was secure and locked, specifically related to medicated creams being left in the spa room by non-registered staff. [s. 129. (1) (a)]

Issued on this 8th day of December, 2017

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

Original report signed by the inspector.