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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 5, 2019	2019_514566_0002	004359-17, 020179-18	Critical Incident System

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)

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): January 22, 23, 28, 29, and 30, 2019.

The following critical incidents were inspected during this inspection: logs #004359 -17 and #020179-18 related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), former DOC, registered nursing staff (RN/RPN), personal support workers (PSW), and residents.

During the course of the inspection, the inspector observed residents, provision of resident care, reviewed residents' health care records, incident notes, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	Légende 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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee shall ensure that the Director was informed of an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

The Ministry of Health and Long-term Care (MOHLTC) received a critical incident system (CIS) report on an identified date in August 2018, related to a fall sustained by resident #001 on an identified date in July 2018, which resulted in an identified injury.

A review of that report and resident #001's progress notes indicated that the resident sustained a fall on an identified date in July 2018. The resident was diagnosed with a specific injury 17 days later. Resident #001 was transferred to hospital the following day, underwent treatment, and was readmitted to the home five days later.

During an interview, RN #101, who responded to the incident and submitted the CIS report, indicated that the home became aware of resident #001's significant change in status prior to the resident's hospitalization, and that the CIS report should have been submitted to the Director when the resident's injury was first identified.

During an interview, Administrator/DOC #100 confirmed that the Director should have received the report regarding resident #001's injury within one business day of the significant change to the resident's health status being identified. [s. 107. (3) 4.]

Issued on this 5th day of February, 2019

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

Original report signed by the inspector.