Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 18, 2019	2019_630589_0028	021248-19	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

JOANNE ZAHUR (589)

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): December 3, 4, & 5, 2019. December 6, & 10, 2019, off-site.

The following intake was inspected concurrently with the Toronto Service Area Office Initiated Inspection:
Log #021248-19 related to a fall incident.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (Admin/DOC), Registered Nurse in-charge (RN-IC), Registered Nurse (RN), Personal Support Worker (PSW), and Accountant.

During the course of the inspection resident health records, the long term care homes (LTCH) private respite admission packages, the LTCH's license and relevant policies were reviewed, and staff to resident interactions and care being provided was observed.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 104. Beds allowed under licence

Specifically failed to comply with the following:

s. 104. (1) A licensee shall not operate more beds in a long-term care home than are allowed under the licence for the home or under the terms of a temporary licence issued under section 111 or a temporary emergency licence issued under section 112.

Findings/Faits saillants :

The licensee has failed to ensure that a licensee does not operate more beds in a long-term care home than are allowed under the license for the home or under the terms of a temporary license issued under section 111 or than are authorized under section 113. 2007, c. 8, s. 104 (1).

The Director received a critical incident system (CIS) report for resident #001. Interviews indicated that resident #001 was a resident in one of the long term care home's (LTCH) private respite beds.

A review of the home’s current census upon entering the LTCH on December 3, 2019, indicated that 34 residents were living in the LTCH.
A review of the home’s Long-Term Care Home License indicated that under license number 2792-L01, effective July 1, 2010, and with an expiry date of June 30, 2025. The number of beds allowed under this license is 34.

An interview with the Administrator/Director of Care indicated that the home has 34 licensed beds and three private respite beds, for a total of 37 beds. The 34 beds are long term care (LTC) beds and are operated in collaboration with the LHIN and the three private respite beds are privately operated by the home. The home has a separate admission package and wait list for these private respite beds. Respite bed applications are reviewed by the LTCH internally and admission into these private respite beds are not authorized by the LHIN.

Rates for these private respite beds is based on the following criteria:
-if the applicant is not Finnish, the rate is $110.00 per day.
-if the applicant is Finnish, is a member of the centre but does not live in the independent living apartments affiliated with the LTCH, they pay $99.00 per day (10 % discount), and
-if Finnish, a member of the centre and lives in the independent living apartments affiliated with the LTCH, they pay $93.50 per day (15% discount).

As a result of an inquiry conducted with the Licensing Branch of the Ministry of Long-Term Care (MLTC), a letter that was issued in 1992 was located, which allowed the LTCH to operate four respite beds privately in addition to their licensed capacity. The inquiry indicated that all over bed approvals/authorizations were extinguished when the Long Term-Care Homes Act (LTCHA) was introduced. Specifically, any authority or permission, express or implied to operate more beds than were licensed under the Nursing Homes Act (NHA) or approved under the Charitable Institutions Act or the Homes for the Aged and Rest Homes Act is extinguished on the day this section comes

into operation, 2007, c. 8, s.188(1). Under the LTCHA, 2007, c. 8, s. 188 (2), & s. 188, (3), refers to the Director issuing a temporary license under section 111, for a term of three years starting on the day this section comes into operation, 2007, c. 8.

During an interview with the LTCH's previous staff #107, they stated these three private respite beds have been in place since 1992 and indicated that it was not a secret, that everyone knew. The Ministry of Long-Term Care (MLTC) provides funding for34 LTC beds only. The private respite resident(s) receives the same services as received by the LTC residents and that's why a percentage of monies that comes in are used for extra staffing to meet their care needs. Staff #107 also acknowledged that the LTCH had not applied to the MLTC to increase their licensed beds at any time.

During an interview, staff #108 stated the billing for these beds is done monthly. Staff #108 further stated approximately seven to eight per cent of monies collected from the private respite beds is used for staffing in the LTCH to provide their care needs.

Staff #104 confirmed the home is operated as a not-for-profit home. [s. 104. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's restraint by a physical device was included in the plan of care.

The Director received a CIS report for resident #001 related to a fall incident with injury.

Observations conducted by the inspector on two identified dates in December 2019, indicated that resident #001 was wearing a physical restraining device while up in their mobility aid.

A review of resident's health record did not indicate the use of a physical restraining device while up in their mobility aid. A further review also indicated there was no physician's order or consent from the substitute decision-maker (SDM).

During an interview, staff #109 stated that after the above noted incident, the physical restraining device was being applied to resident #001's mobility aid when up, but that they could release the physical restraining device when asked.

Further observations indicated that resident #003 could not release the physical restraining device when asked verbally and with using hand gestures.

During an interview, staff #104 acknowledged that resident #001's physical restraining device had not been included in their plan of care. [s. 31. (1)]

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 a resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to ensure that an analysis of the restraining of residents by use of a physical device is undertaken on a monthly basis.

During a conversation, staff #104 acknowledged that an analysis of the restraining of residents by use of a physical device had not been undertaken on a monthly basis, and therefore, was unable to provide this document. [s. 113. (a)]

2. The licensee has failed to keep a written record of the restraint program's annual evaluation, that included the following:
•the monthly analysis, and the changes and improvements required;
•the date of the annual evaluation;
•the names of the persons who participated in the evaluation; and
•the date that the changes were implemented.

A review of the 2018 annual evaluation of the restraint program identified the following points:
•falls and restraints continue to be reviewed monthly by program lead, and as required, continue for 2019,
•referrals to physiotherapy (PT) and occupational therapy (OT), as issues arise, completed as required, continue for 2019,
•follow recommendations of PT and OT and best practice. Continue to practice preventative measures, continue in 2019,
•staff education annually and as needed through in-services and e-learning, continue in 2019,
•improve turning and positioning routines while in wheelchair and in bed to prevent discomfort and restlessness, continue in 2019,
•update care plans as necessary, continue in 2019.

During a conversation, staff #104, acknowledged that the 2018 annual evaluation of the restraint program did not meet legislative requirements as identified above. [s. 113. (e)]

Issued on this 24th day of December, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JOANNE ZAHUR (589)
Inspection No. / No de l'inspection :	2019_630589_0028
Log No. / No de registre :	021248-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 18, 2019
Licensee / Titulaire de permis :	Toronto Finnish-Canadian Seniors Centre 795 Eglinton Avenue East, TORONTO, ON, M4G-4E4
LTC Home / Foyer de SLD :	Suomi-Koti Toronto Nursing Home 795 Eglinton Avenue East, TORONTO, ON, M4G-4E4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kathleen Francis

To Toronto Finnish-Canadian Seniors Centre, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 104. (1) A licensee shall not operate more beds in a long-term care home than are allowed under the licence for the home or under the terms of a temporary licence issued under section 111 or a temporary emergency licence issued under section 112.

Order / Ordre :

The licensee must be compliant with s. 104. (1) of the LTCHA, 2007.

Specifically, the licensee must do the following:
a. Cease operation of the unlicensed respite bed immediately after the occupant is discharged.
b. Within one business day of receiving this order, forward a copy to the Toronto Central Local Health Integration Network (TC-LHIN).
c. Work collaboratively with the TC-LHIN to ensure all necessary steps are taken as per the LTCHA, 2007, and its regulations to relocate the residents to a long-term
care bed within 60 days of receiving this order.

Grounds / Motifs :

1. The licensee has failed to ensure that a licensee does not operate more beds in a long-term care home than are allowed under the license for the home or under the terms of a temporary license issued under section 111 or than are authorized under section 113. 2007, c. 8, s. 104 (1).

The Director received a critical incident system (CIS) report for resident #001. Interviews indicated that resident #001 was a resident in one of the long term care home's (LTCH) private respite beds.

A review of the home's current census upon entering the LTCH on December 3, 2019, indicated that 34 residents were living in the LTCH.
A review of the home's Long-Term Care Home License indicated that under license number 2792-L01, effective July 1, 2010, and with an expiry date of June

30, 2025. The number of beds allowed under this license is 34.

An interview with the Administrator/Director of Care indicated that the home has 34 licensed beds and three private respite beds, for a total of 37 beds. The 34 beds are long term care (LTC) beds and are operated in collaboration with the LHIN and the three private respite beds are privately operated by the home. The home has a separate admission package and wait list for these private respite beds. Respite bed applications are reviewed by the LTCH internally and admission into these private respite beds are not authorized by the LHIN.

Rates for these private respite beds is based on the following criteria:
-if the applicant is not Finnish, the rate is $110.00 per day.
-if the applicant is Finnish, is a member of the centre but does not live in the independent living apartments affiliated with the LTCH, they pay $99.00 per day (10 % discount), and
-if Finnish, a member of the centre and lives in the independent living apartments affiliated with the LTCH, they pay $93.50 per day (15% discount).

As a result of an inquiry conducted with the Licensing Branch of the Ministry of Long-Term Care (MLTC), a letter that was issued in 1992 was located, which allowed the LTCH to operate four respite beds privately in addition to their licensed capacity. The inquiry indicated that all over bed approvals/authorizations were extinguished when the Long Term-Care Homes Act (LTCHA) was introduced. Specifically, any authority or permission, express or implied to operate more beds than were licensed under the Nursing Homes Act (NHA) or approved under the Charitable Institutions Act or the Homes for the Aged and Rest Homes Act is extinguished on the day this section comes into operation, 2007, c. 8, s.188(1). Under the LTCHA, 2007, c. 8, s. 188 (2), & s. 188, (3), refers to the Director issuing a temporary license under section 111, for a term of three years starting on the day this section comes into operation, 2007, c. 8.

During an interview with the LTCH's previous staff #107, they stated these three private respite beds have been in place since 1992 and indicated that it was not a secret, that everyone knew. The Ministry of Long-Term Care (MLTC) provides funding for 34 LTC beds only. The private respite resident(s) receives the same services as received by the LTC residents and that's why a percentage of

monies that comes in are used for extra staffing to meet their care needs. Staff #107 also acknowledged that the LTCH had not applied to the MLTC to increase their licensed beds at any time.

During an interview, staff #108 stated the billing for these beds is done monthly. Staff #108 further stated approximately seven to eight per cent of monies collected from the private respite beds is used for staffing in the LTCH to provide their care needs.

Staff #104 confirmed the home is operated as a not-for-profit home. [s. 104. (1)]

This non-compliance is warranted as a result of the licensee operating three unlicensed beds in the home.

The severity of the non-compliance is at level 1 (minimum risk), the scope is a level 3 (wide-spread) as all three private respite beds are occupied by residents, and that the home has been operating these unlicensed beds since 1992. The compliance history is a level 2, as previous non-compliance(s), are in unrelated areas. (589)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 20, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 18th day of December, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Joanne Zahur

Service Area Office /
Bureau régional de services : Toronto Service Area Office