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

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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
May 31, Jun 2, 2021	2021_526645_0010	002391-21, 003182-21	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

DEREGE GEDA (645)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 21, 22, 23, 26, 27 and 28, 2021.

This inspection was completed to inspect upon the following intakes:
- log# 002391-21, Critical Incident System (CIS) report number 2792-000001-21, related to fall prevention and management and
- log# 003182-21, for a follow up inspection under Safe and Secure home.

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

During the course of the inspection, the inspector observed the provision of care, services and supplies; reviewed records including but not limited to relevant training records, policies and procedures, residents' clinical health records, and staff schedules.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
4 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 5.	CO #001	2020_754764_0017	645

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. 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:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions.

Resident #001 was hospitalized and the physician determined the resident palliative upon return to the home and treatments were ordered. Resident #001's plan of care did not contain a palliative care focus, and there were no interventions implemented to promote the resident's comfort.

RN #100 confirmed that there was no palliative plan of care developed for resident #001. They indicated that it was the expectation of the home that registered staff initiate a palliative plan of care when residents' health condition changed to palliative care measures.

2. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions.

Resident #002 had a fall sustaining injury. The progress notes indicated interventions to include in the plan of care to prevent further incidents. There was no plan of care initiated for fall prevention and the above mentioned interventions were not implemented.

RN #100 confirmed that the above mentioned interventions were not included or developed in the resident's care plan. They indicated that it was the expectation of the home that registered staff develop a fall prevention interventions and include them in the resident's plan of care.

Sources: residents #001’s and #002's plan of care and progress notes, assessment records and interviews. [s. 26. (3) 10.]

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 plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions including allergies, pain, risk of falls and other special needs, to be implemented voluntarily.

WN #2: 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #001 was reassessed and the plan of care was revised because the care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care.

A Critical Incident System(CIS) report was submitted to the Ministry of Long-Term Care (MLTC) related to an incident that caused an injury to resident #001.

The resident had multiple recurring incidents from December 2020 to March 2021. The resident's plan of care was updated with incident prevention interventions in December, 2020. The resident plan of care was not updated; interventions were not evaluated for effectiveness and new interventions were not implemented when the resident had subsequent incidents in January, February and March 2021.

The DOC indicated that following each incident of this type, registered staff were expected to reassess the resident, develop interventions and update the plan of care. The DOC reiterated that recurring incidents were the result of unmet needs or ineffective interventions, and required reassessment to prevent further incidents and injuries.

Sources: resident #001’s plan of care and progress notes, and interview with the DOC. [s. 6. (11) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's identified type of incident prevention and management policy was complied with.

As required by the Regulation (O. Reg. 79/10, s. 48 (1). 1) the licensee was required to have the identified incident prevention and management policy implemented in the home.

The home's policy directed staff members to complete incident risk and injury assessments, and conduct a thorough investigation to identify the antecedent causes of the incident and develop interventions.

Resident #001 had multiple recurring incidents in November, December 2020, February and March 2021. Following the incidents, the home did not complete the above mentioned assessments and incident investigations.

Interview with RN #100 confirmed that the above-mentioned assessments were not completed. The DOC reiterated that it was the expectation of the home that registered staff complete the required assessments, determine antecedent causes and develop interventions.

Sources: resident #001’s plan of care and progress notes, and interviews [s. 8. (1) (a),s. 8. (1) (b)]

WN #4: 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 has failed to ensure that the Director was immediately informed of an incident that caused injury requiring hospitalization of resident #001 and resulted in a significant change in health condition.

On an identified date, resident #001 had an identified type of incident and sustained an injury. The resident was hospitalized and determined to be palliative after hospitalization. Prior to the incident, the resident was independent with the activity of daily living and used an assistive device for ambulation. Following the incident, the resident became bed bound and required total assist/care for activity of daily living.

Inspector #645 reviewed the Long-Term Care Homes.net reporting website and was unable to locate a mandatory critical incident report submitted by the home, regarding the incident that had caused a significant injury to the resident.

The DOC confirmed that the above incident was not reported to the Director. They indicated that there was a significant injury to the resident and the expectation was to complete the incident report.

Sources: the Long-Term Care Homes.net reporting website, resident #001's progress notes, and interview with the DOC. [s. 107. (3) 4.]

Issued on this 1st day of June, 2021

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

Original report signed by the inspector.