Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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
Jan 18, 2022	2022_937759_0002	014436-21	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

APRIL CHAN (704759)

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 6, 7, 10, and 11, 2022.

The following intake was completed in this Critical Incident System (CIS) inspection:
Log #014436-21, CIS report number 2792-000004-21, related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC)/Infection Prevention and Control (IPAC) Lead, Falls Lead, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), screening staff, housekeeping staff and residents.

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

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
1 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 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned care of using a fall monitor for a resident was set out in the written plan of care.

A CIS report was received by the Ministry of Long-Term Care for a fall incident that resulted in an injury to the resident for which the resident was taken to hospital and resulted in a significant change in health status.

The resident was at risk for falls. They had cognitive and physical impairments, and used a mobility aid.

On a specific date, the resident had an unwitnessed fall that resulted in pain and an injury and was sent to the hospital for assessment and treatment. The resident returned back to the home and was reassessed by a physiotherapist who recommended implementation of a fall monitor.

An RPN and the Falls Lead suggested that the use of a fall monitor was implemented for short period of time for the resident. However, the fall monitor was discontinued after a short time. The RPN stated that it was important to document the implementation of the fall monitor so that there was communication regarding the use of fall monitor and that the written plan of care should have been updated.

Sources: CIS report, review of the resident’s clinical records, and interviews with staff members. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the planned care of a specific intervention for a resident to prevent falls was set out in the written plan of care.

The resident was at risk for falls. They had cognitive and physical impairments. The Falls lead identified a specific intervention to prevent falls was implemented. This specific intervention was not included in the written plan of care for fall prevention for the resident.

Sources: Review of the resident’s clinical records, and interview with Falls Lead. [s. 6. (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 to ensure that the written plan of care each resident sets out the planned care for the resident, to be implemented voluntarily.

Issued on this 3rd day of February, 2022

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

Original report signed by the inspector.