Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: March 7, 2023	
Inspection Number: 2023-1282-0001	
Inspection Type: Proactive Compliance Inspection	
Licensee: Toronto Finnish-Canadian Seniors Centre	
Long Term Care Home and City: Suomi-Koti Toronto Nursing Home, Toronto	
Lead Inspector Nira Khemraj (741716)	**Inspector Digital Signature** Niranjani Khemraj Digitally signed by Niranjani Khemraj Date: 2023.03.03 13:57:54 -05'00'
Additional Inspector(s) Matthew Chiu (565)	

INSPECTION SUMMARY

The inspection occurred on the following date(s): February 14, 15, 16, 17, 21, 22, 23 and 27, 2023.

The following intake(s) were inspected:

- Intake: #00020439 - Proactive Compliance Inspection

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 148 (2)(1)

The licensee has failed to ensure that drugs that are to be destroyed and disposed of were stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.

In accordance with O.Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that pharmacy policies and procedures on Drug destruction were complied with.

Rationale and Summary
As per the policy on Drug Destruction, it is indicated that waste containers containing discarded medications should be sealed and stored in a secure space, accessible to only registered staff.

Observations of the waste container in the secured spaced on the home area indicated that the lid of the waste container was not sealed, and previously discarded medications were accessible. Registered Nurse (RN) #111 demonstrated that they had access to previously discarded medications by opening the lid of the waste container. RN #111 acknowledged the lid should be sealed to prevent access to discarded medications.

During observations on February 17, 2023, the waster container was observed to be sealed.

Sources: Observations of waste container, review of pharmacy policies and procedures, and interview with RN #111.

Date remedy implemented: February 17, 2023
[741716]

WRITTEN NOTIFICATION: Directives by Minister

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to carry out the COVID-19 asymptomatic screen testing requirements directive that applied to the long-term care home.

Rationale and Summary:
The Minister's Directive, COVID-19 guidance document for long-term care homes in Ontario directed the homes to ensure that all residents are assessed at least once daily for signs and symptoms of COVID-19, including temperature checks.

Record review and staff interviews confirmed that when a resident did not demonstrate any signs and symptoms, their monitoring did not include temperature checks for the residents at least daily as required.

The non-compliance caused a risk for daily monitoring of signs and symptoms of COVID-19 among residents.

Sources: Resident's temperature records; interviews with RN #117 and IPAC Lead #109.

[565]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (15)

The licensee has failed to ensure that the infection prevention and control (IPAC) lead designated under this section worked regularly in that position on site at the home for at least 17.5 hours per week.

Rationale and Summary:
The home had licensed bed capacity of fewer than 69 beds and had a staff member designated as the lead for their IPAC and another care program.

The home's IPAC lead job description did not specify the number of work hours designated on-site towards their IPAC lead responsibilities. Review of the home's weekly work schedule and staff interviews confirmed that their designated IPAC lead did not meet the hours per week as required.

The non-compliance increased risk that the home's IPAC program, practice, and standard would not be implemented.

Sources: IPAC lead job description, weekly work schedule; interviews with IPAC Lead #109 and the Administrator/Director of Care.

[565]

WRITTEN NOTIFICATION: Additional Training — Direct Care Staff

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 261 (2)

The licensee has failed to ensure that all staff who provided direct care to residents received annual training provided for in the areas required under subsection 82 (7) of the Act related to falls prevention and management, skin and wound care, and pain management.

Rationale and Summary:
Staff interviews and training records indicated the home used online courses to provide their annual training to direct care staff for falls prevention and management, skin and wound care, and pain management in year 2022. Review of the training records for these courses indicated several direct care staff failed to complete the assigned training in year 2022 as required.

Sources: Staff training records; interviews with Clinical Support Nurse (CSN) #106 and other staff.

[565]

WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (1)

The licensee failed to ensure that at least once every year a survey is taken of the residents, their families and caregivers to measure their experience with the home and the care, services, programs and goods provided at the home.

Rationale and Summary
DOC #100 was requested to provide the results of the Resident Satisfaction Survey (RSS) and Family Satisfaction Survey (FSS) for the year 2022. DOC #100 confirmed that there were no records of an RSS and FSS completed for the year 2022.

Failure of the home to complete the RSS and FSS as required may have led to the home not being made aware of necessary improvements to be made based on the survey outcomes.

Sources: Interview with DOC #100 and records of RSS and FSS.
[741716]

WRITTEN NOTIFICATION: Medication Incidents and Adverse Drug Reactions

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 147 (3) (c)

The licensee failed to ensure that a quarterly review of all medication incidents and adverse drug reactions including any changes or improvements implemented was completed and that a written record was kept.

Rationale and Summary
DOC #100 was requested to provide the quarterly medication review completed for the year 2022. DOC #100 provided individual medication incidents completed for 2022 and confirmed that there was no written record of the quarterly review for the medication incidents and adverse drug reactions for the year 2022.

Failure of the home to conduct the quarterly review of medication incidents and adverse drug reactions may have led to an increased risk of medication incidents and adverse drug reactions.

Sources: Interview with DOC #100 and review of submitted medication incidents.
[741716]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 166 (3)(1)

The licensee failed to ensure that the Continuous Quality Improvement (CQI) committee monitored and reported to the long-term care home licensee on quality issues, residents' quality of life, and the overall quality of care and services provided in the long-term care home, with reference to appropriate data.

Rationale and Summary

Review of the CQI meeting minutes for 2022, showed no reference to the home monitoring the quality of care and services provided in the home through the use of appropriate data. In an interview with DOC #100, it was confirmed that the CQI minutes outlined all data that was discussed and acknowledged that the home did not reference appropriate data related care and services provided.

Failure of the home to review appropriate data related to care and services provided may have led to areas of improvement not being identified and addressed in the home.

Sources: Interview with DOC #100 and review of CQI meeting minutes.
[741716]