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
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Toronto, ON, M2M 4K5
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Original Public Report

Report Issue Date: June 11, 2024	
Inspection Number: 2024-1282-0001	
Inspection Type: Complaint	
Licensee: Toronto Finnish-Canadian Seniors Centre	
Long Term Care Home and City: Suomi-Koti Toronto Nursing Home, Toronto	
Lead Inspector Slavica Vucko (210)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 30, 31, 2024 and June 3, 2024.

The following intake(s) were inspected:

- Intake: #00113601 -complaint related to hospital transfer, resident care services, continence care, transferring/positioning techniques, communication methods, housekeeping and dealing with complaints.

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

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

Rationale and Summary

The resident's written plan of care indicated that the resident required a specific method of transfer.

Interview with staff indicated that during certain type of care the resident was transferred with a method that was different than the written plan of care. The resident was not assessed by the appropriate interdisciplinary team member prior to the staff using the above-mentioned method.

Interview with the Physiotherapist (PT) indicated that during the inspection they reassessed the resident's method of transfer and they updated the care plan to

reflect that the resident can tolerate the transfer method staff was using. Further, they stated that staff did not send referral to the PT for reassessment in order for the resident to be assessed for the method of transfer as required.

Failure to ensure that staff collaborated with each other in the assessment of transfer can lead to an increased risk of injury to resident #001.

Sources: resident's family member, resident, clinical record and interviews with staff.

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