

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: December 08, 2023	
Inspection Number: 2023-1282-0002	
Inspection Type: Critical Incident	
Licensee: Toronto Finnish-Canadian Seniors Centre	
Long Term Care Home and City: Suomi-Koti Toronto Nursing Home, Toronto	
Lead Inspector Kirthiga Ravindran (000760)	Inspector Digital Signature
Additional Inspector(s) Christine Francis (740880) attended this inspection.	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 16-17, 20-21, 2023

The inspection occurred offsite on the following date(s): November 22, 2023

The following intake was completed in this Critical Incident (CI) inspection:

- Intake #00094273/CI#2792-000001-23- was related to falls prevention and management

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

- Infection Prevention and Control
- Falls Prevention and Management

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INSPECTION RESULTS

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (1)

54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that Head Injury Routine (HIR) was continued for a resident when they had a fall.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to have a falls prevention and management program that provided strategies to monitor residents and must be complied with. Specifically, registered nursing staff did not comply with the home's Head Injury policy to complete HIR monitoring during the first 24-hours after a fall.

Rationale and Summary

A resident sustained an unwitnessed fall which resulted in a head injury.

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The home's Policy directs the nurse to complete the HIR monitoring for a 24-hour period when a resident sustains a head injury.

The resident's clinical records indicated the HIR monitoring was not completed during the specified duration.

The Registered Practical Nurse (RPN) acknowledged HIR monitoring was not completed for the resident.

Failure to complete head injury routine for the resident after a fall put them at risk of health changes not being identified if not being monitored.

Sources: Resident clinical records, Interview with RPN, home's Policy.

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WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

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The licensee failed to ensure that a skin and wound assessment was completed for a resident when they had altered skin integrity.

Rationale and Summary

A resident sustained an unwitnessed fall which resulted in altered skin integrity.

The resident clinical records indicated skin and wound assessment was not completed for the resident after they returned from hospital.

An RPN stated they did not complete a skin and wound assessment for the resident, and acknowledged it should have been completed upon the resident's return from hospital.

Failure to complete a skin and wound assessment when the resident had altered skin integrity delayed the identification and treatment.

Sources: Resident clinical records, interview with RPN

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