

Public Report

Report Issue Date: August 11, 2025

Inspection Number: 2025-1282-0002

Inspection Type:
Complaint

Licensee: Toronto Finnish-Canadian Seniors Centre

Long Term Care Home and City: Suomi-Koti Toronto Nursing Home, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: July 29-31, 2025, and August 6-8, 11, 2025.

The inspection occurred offsite on the following date: August 1, 2025

The following intakes were inspected in this complaint inspection:

Intake: #00150923 – was related to withholding approval for admission.

Intake: #00154292 – was related to obstruction.

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

Whistle-blowing Protection and Retaliation
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Licensee Consideration and Approval

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

Non-compliance with: FLTCA, 2021, s. 51 (7) (b)

Authorization for admission to a home

s. 51 (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 50 (6), and the licensee shall review the

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

assessments and information and shall approve the applicant's admission to the home unless,

(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements;

The licensee has failed to ensure that withholding approval for an applicant's admission to the home was based on a lack of nursing expertise to meet the applicant's care requirements.

A letter withholding admission indicated that the home lacked the nursing expertise to meet the applicant's care requirements due to active and historical behavioural symptoms with potential to escalate. The long-term care (LTC) application documents from Ontario Health at Home (OHAA) indicated that verbal and physical responsive behaviours were not exhibited by the applicant. The Behavioural Support Ontario (BSO) Lead verified that when individuals with responsive behaviours were admitted, developing and implementing interventions to manage such behaviors was within their role and area of expertise.

Sources: Applicant's application documents and letters withholding approval for admission; and interview with BSO Lead.

WRITTEN NOTIFICATION: Licensee Consideration and Approval

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

Non-compliance with: FLTCA, 2021, s. 51 (7) (c)

Authorization for admission to a home

s. 51 (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 50 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,

(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval.

The licensee has failed to ensure that withholding approval for applicant's admission to the home was based on circumstances that existed which were provided for in the regulations as being a ground for withholding approval.

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

A letter withholding admission cited provisions in the Fixing Long-Term Care Act (FLTCA) that precluded the applicant's admission into the home. Such provisions did not exist for applicants in the FLTCA.

Sources: Applicant's application documents and letters withholding approval for admission; and interview with Director of Care (DOC)/Administrator.

WRITTEN NOTIFICATION: Written Notice if Licensee Withholds Approval

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 51 (9)

Authorization for admission to a home

s. 51 (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,

- (a) the ground or grounds on which the licensee is withholding approval;*
- (b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care;*
- (c) an explanation of how the supporting facts justify the decision to withhold approval;*
- and*
- (d) contact information for the Director.*

The licensee has failed to ensure that a written notice withholding approval for admission to the LTC home was given to an applicant. A written notice was sent to the placement coordinator and not directly to the applicant.

Sources: Letters withholding approval for admission; and interview with DOC/Administrator.

WRITTEN NOTIFICATION: Coercion Prohibited

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 89 (1)

Coercion prohibited

s. 89 (1) Every licensee of a long-term care home shall ensure that no person is told or

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

led to believe that a prospective resident will be refused admission or that a resident will be discharged from the home because,

*(a) a document has not been signed;
(b) an agreement has been voided; or
(c) a consent or directive with respect to treatment or care has been given, not given, withdrawn or revoked.*

The licensee has failed to ensure that an applicant was not told or led to believe that they would be refused admission because they had not signed a document, did not follow through with an agreement and had not given consent with respect to treatment and care.

The home approved an applicant as a match and scheduled admission for the following week. The applicant arrived as pre-arranged and they were refused admission because they did not sign documents that were designated as part of the admission process and a family member did not abide by a previous agreement to call the home prior to the date of admission.

Sources: Email correspondence between the home and OHAH, letters withholding approval for admission; and interviews with the DOC/Administrator and other relevant staff.

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

Reports re critical incidents

s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):

5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed of an outbreak that was declared by Toronto Public Health (TPH).

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

Source: TPH outbreak confirmation email, Ontario LTC Homes Portal; and interview with the IPAC Lead.

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

Reports re critical incidents

s. 115 (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 (5):

4. Subject to subsection (4), 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.

The licensee has failed to ensure the Director was informed of an injury to a resident for which they were taken to a hospital and resulted in a significant change in the resident's health condition.

A resident was taken to a hospital after an injury that resulted in significant change to their health condition that lasted for a few weeks. The Director was not informed of the incident.

Sources: Resident's clinical records and Ontario LTC Homes Portal; and interview with a Registered Nurse (RN).