Ontario

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

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

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

Public Report

Report Issue Date: December 2, 2025
Inspection Number: 2025-1282-0003
Inspection Type: Critical Incident
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 date(s): November 26-28, and December 2, 2025.
The inspection occurred offsite on the following date(s): December 1, 2025.

The following Critical Incident (CI) intake was inspected:

- Intake: #00157831 / CI 2792-000001-25 - Related to falls prevention and management.

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

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A resident care plan indicated that vital signs were to be monitored each shift. Two

Registered Nurses (RNs) indicated that vital signs were not monitored each shift.

Sources: Resident clinical records; interviews with two RNs.

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #002 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.

A resident experienced an unwitnessed fall with injury. An RN acknowledged that the Director should have been informed of this incident no later than one business day after its occurrence.

Sources: Resident clinical records; interview with an RN.