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

Public Report

Report Issue Date: March 11, 2026
Inspection Number: 2026-1282-0002
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): March 2-5, 9 and 11, 2026
The inspection occurred offsite on the following date(s): March 6, 2026

The following intakes were completed in this Critical Incident (CI) inspection:

Intake: #00163735 (CI #2792-000002-25) was related to unknown cause of injury to a resident.

Intake: #00166019 (CI #2792-000005-25) was related to falls prevention and management.

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

Resident Care and Support Services
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)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

i) The signage identified in a resident's bedroom did not reflect the correct assistance required. A staff member acknowledged that the signage needed to be updated. The home updated the signage to reflect the accurate care assistance required for the resident.

Sources: Observations, resident clinical records, and interviews with relevant staff

ii) A resident's care plan indicated the use of a specific mobility device. Based on observation and interviews with staff members, the resident was no longer using that device and had transitioned to different mobility device. The home updated the resident's care plan to reflect the mobility device that was currently in use.

Sources: Observation, resident clinical records; and interviews with relevant staff.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

A resident's care plan contained unclear directions regarding the use of an assistive device. One section of the plan required the use of a single device, while another section required the use of two devices, resulting in contradicting instructions. Staff members confirmed that the directions were unclear to those providing care to the resident.

Sources: Observation, resident clinical records; and interviews with relevant staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 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.

i) The home submitted a CI regarding a fall incident that resulted to a significant change in resident's health condition. The incident was reported two days late to the Director based on the reporting requirements.

Sources: CI report, resident clinical records; and interview with a staff member.

ii) A resident sustained a significant injury that required reporting to the Director. The home did not report the incident in a timely manner, as required by reporting requirements.

Sources: CI report, resident clinical records, and interview with a staff member.