Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 9, 2013	2013_162109_0001	T2192-12	Critical Incident System

Licensee/Titulaire de permis

TORONTO FINNISH-CANADIAN SENIORS CENTRE
795 EGLINTON AVENUE EAST, TORONTO, ON, M4G-4E4

Long-Term Care Home/Foyer de soins de longue durée

SUOMI-KOTI TORONTO NURSING HOME
795 EGLINTON AVENUE EAST, TORONTO, ON, M4G-4E4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SUSAN SQUIRES (109)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 7, 2013

This inspection corresponds with log # T2192-12

During the course of the inspection, the inspector(s) spoke with ADOC, Registered nursing staff, Personal Support Workers

During the course of the inspection, the inspector(s) Reviewed the health care record for the identified resident

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident # 1 was provided with the personal assistance and encouragement required to safely eat.
Resident # 1 choked on a sandwich and died from asphyxiation. Resident # 1's plan of care stated that he/she required constant supervision and assistance to eat any foods. Staff were required to break food items into small pieces and sit with the resident to ensure that he/she ate one piece at a time. He/she was to be supervised at mealtime and at snack time and staff were to sit beside him/her and cut his/her food into small pieces.
On an identified date a PSW fed resident # 1 some of his/her sandwich and left approximately half of the sandwich for him/her to feed themself. The resident choked on the sandwich and died at the home. This was confirmed by another PSW who witnessed the 1/2 sandwich sitting on a table after the resident had died. [s. 73. (1) 9.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are provided with the personal assistance and encouragement required to safely eat, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (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 (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee failed to immediately inform the Director in as much detail as is possible in the circumstance of an unexpected or sudden death, including a death resulting from an accident or suicide.
Resident # 1 died suddenly on an identified date of asphyxiation and the licensee did not inform the Director until 3 days later. [s. 107. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance toe ensure that the Director is informed in as much detail as is possible in the circumstances of an unexpected or sudden death, including a death resulting from an accident or suicide, to be implemented voluntarily.

Issued on this 14th day of January, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs