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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 17, 2017	2016_370649_0026	017158-16, 025181-16, 025346-16	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

JULIEANN HING (649)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 7, 8, 9 and 12, 2016.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Physiotherapist, Physiotherapist Assistant, Housekeeper, and residents.

During the course of the inspection, the Inspector observed staff to residents interactions, conducted interviews, reviewed relevant policies, and residents' health records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Pain

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 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. 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provided direct care to the resident.

On a specified date in August 2016, a Critical Incident System (CIS) report submitted to the Ministry of Health and Long-Term Care (MOHLTC) revealed that an identified resident had been diagnosed with a specified medical condition after sustaining falls. The identified resident was provided with an identified personal assistive device until he/she recovered.

A review of the identified resident's most current written plan of care with an effective date of August 2016, directed staff to use one type of personal assistive device at all times as well as to use a different type of assistive device when resident was out of bed. The written plan of care further directed staff to transfer the identified resident with extensive assistance but did not indicate how many staff.

On September 8, 2016, the identified resident was observed being transferred by PSW #051 to a standing position using the one type of personal assistive device then walked from outside of the TV room to his/her room a couple doors down the hallway to the washroom and then back again. A transfer logo posted above the resident bed in his/her

room revealed that the identified resident should be transferred by two staff.

In an interview PSW #051 told the Inspector that the identified resident required extensive assistance with two staff for transfers and had been transferred before breakfast with two staff. PSW #051 further stated that the resident could be transferred by one or two staff depending on his/her condition and that the identified resident's written plan of care did not provide clear directions on how many staff were required to transfer and walk the resident in corridor/room.

In an interview RN #056 stated that the identified resident's written care plan did not provide clear directions to staff and others who provide direct care to the resident.

The DOC confirmed that the identified resident's written plan of care did not provide clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident was assessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary.

On August 2016, a CIS report was submitted to the MOHLTC related to an identified resident who had been found sitting on the floor in the washroom. The identified resident was transferred to the hospital after the fall where he/she was diagnosed with a medical condition.

A review of the identified resident's written care plan dated September 2016, under transferring and falls/balance directed staff to transfer resident using a mechanical lift if non weight bearing with two staff as well as to ensure use of a personal assistive device for ADL (activity of daily living). The care plan also stated no walking due to a medical condition.

On September 8, 2016, after lunch the identified resident had been observed being transferred from his/her wheelchair back to bed using a mechanical lift assisted by two staff and had not been observed using the personal assistive device for transfers or ADL.

In interviews PSW #063, RPN #062, and Physiotherapist #055 revealed that the identified resident was being transferred with a mechanical lift after being diagnosed with

a medical condition. PSW #063, RPN #062, and Physiotherapist #062 further revealed the resident had used a walker prior to the medical condition and stated that it should have been removed from the identified resident's plan of care after his/her status changed.

DOC confirmed that the resident plan of care had not been reviewed and revised when the identified resident's care needs had changed. [s. 6. (10) (b)]

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 the resident's written plan of care provide clear direction to staff and others who provide direct care to the resident and to ensure that the resident is assessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A review of (CIS) report submitted in June 2016, to the MOHLTC indicated the identified resident was transferred to the hospital on an identified date, where he/she was diagnosed with a medical condition.

A review of the identified resident's health records indicated that the resident pain had not been assessed after he/she returned from hospital after being diagnosed with a medical condition.

A review of the home's Pain Management Program dated March 2011, on page two of the policy indicated that nursing staff should conduct and document a pain assessment:
- upon re-admission
- when there is a significant change
- initiation of a pain medication or PRN analgesic
- any change in condition with the onset of pain
- receiving pain related medication for greater than 72 hours.

During an interview RN #056 told the Inspector that the identified resident had reported pain upon return from hospital and that his/her pain had not been reassessed.

The DOC confirmed that the home's pain policy had not been complied with and the identified resident's pain had not been reassessed upon re-admission from the hospital. [s. 8. (1) (a),s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

In August 2016, a CIS report submitted to the MOHLTC related to an identified resident who had been found sitting on the floor in the washroom. The identified resident was transferred to the hospital after a fall where he/she was diagnosed with a medical condition.

A review of the identified resident's health records indicated that resident had not been assessed after he/she fell on an identified date in August 2016, and was diagnosed with a medical condition.

Interview with RN #056 revealed that it has been the home's practice to complete a post fall note and a post fall assessment in Med e-care after a resident had a fall. RN #056 was unable to provide any documentation of a post fall assessment completed after the identified resident fell on an identified date in August 2016, and was diagnosed with a medical condition.

The DOC confirmed that the home had not assessed the identified resident after his/her fall using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (2)]

2. In August 2016, a CIS report submitted to the MOHLTC revealed that an identified resident had been diagnosed with a medical condition after sustaining falls on specified dates in August 2016. The identified resident was provided an identified personal assistive device for locomotion until he/she recovered.

A review of the identified resident’s health records indicated that the resident had not been assessed after he/she fell on identified dates in August 2016, and was disgnosed with a medical condition.

In interview RPN #062 told Inspector that it has been the home’s practice to complete a post fall assessment after a resident falls. RPN #062 was unable to provide any documentation of an assessment completed after the identified resident fell on specified dates in August 2016, and was diagnosed with a medical condition.

The DOC confirmed that the home had not assessed the identified resident after he/she fell on specified dates in August 2016, using a using clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (2)]

Issued on this 9th day of February, 2017

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

Original report signed by the inspector.