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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 30, 2015	2015_334565_0014	T-711-13, T-733-13, T-2085-15	Critical Incident System

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET METRO HALL, 11th FLOOR TORONTO ON M5V 3C6

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

CUMMER LODGE
205 CUMMER AVENUE NORTH YORK ON M2M 2E8

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

MATTHEW CHIU (565), JULIET MANDERSON-GRAY (607)

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): June 24, 26, and 29, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Nurse Manager (NM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Care Aides (PCAs), residents and family members.
The inspectors conducted a tour of the resident home areas, observations of staff and resident interactions, provision of care, record review of resident and home records, staff training records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

A review of resident #3's incident report revealed on an identified date, when a registered staff gave medication to the resident, an identified incident occurred and as a result, the resident sustained an injury with an identified altered skin integrity.

Record review of the resident's progress notes and clinical assessments indicated the resident did not receive a skin assessment for the above mentioned skin condition.

Interviews with RPN #107, #109 and the NM confirmed the above mentioned incident. The NM indicated the home uses a weekly ulcer/wound assessment record for assessing the identified altered skin integrity and confirmed the resident did not receive a skin assessment using a clinically appropriate assessment instrument for his/her identified altered skin integrity. [s. 50. (2) (b) (i)]

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 that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #2: 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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff who provide direct care to a resident are kept aware of the contents of the resident's plan of care.

A review of resident #2's plan of care indicated and interview with RPN #103 confirmed the resident had physical impairment and required an identified type of mechanical lift with two-person assistance for transfer from bed to wheelchair or toilet.

An interview with PCA #102 revealed when transferring the resident from wheelchair to toilet, the identified type of mechanical lift would be used. When transferring the resident from bed to wheelchair, he/she would use another identified type of mechanical lift because the resident required more assistance.

The PCA further confirmed he/she was not aware that the resident's plan of care did not indicate the use of the other identified type of mechanical lift for transferring the resident. [s. 6. (8)]

WN #3: 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. (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 (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital, no later than one business day after the occurrence of the incident, followed by the report required under subsection (4).

a. Record review of resident #1's progress notes revealed he/she fell on an identified date causing an injury to the resident that resulted in a significant change in the resident's health condition. The resident was sent to the hospital on the same day and was diagnosed with an identified medical condition.

A review of the critical incident report #M512-000095-13 indicated and interview with the DON confirmed the above mentioned incident was reported to the Director two business days after the occurrence of the incident.

b. Record review revealed resident #2 fell on an identified dated and sustained an identified injury that resulted in a significant change in the resident's health condition. The resident was sent to the hospital on an identified date and was diagnosed with an identified medical condition.

A review of the critical incident report #M512-000093-13 indicated and interview with the DON confirmed the above mentioned incident was reported to the Director three business days after the occurrence of the incident. [s. 107. (3) 4.]

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Issued on this 31st day of July, 2015

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

Original report signed by the inspector.