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
Nov 25, 2016	2016_413500_0011	027311-16	Resident Quality Inspection

Licensee/Titulaire de permis

City of Toronto
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

NITAL SHETH (500), DEREGE GEDA (645), VALERIE JOHNSTON (202)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): September 8, 9, 12, 13, 14, 15, 16, 19, 20, 21, 22, 23, 26, 27, 28, 2016.

The following intakes were inspected concurrently during this RQI:
Critical Incident (CI) Intakes related to staff to resident abuse #015889-15, resident to resident abuse #031446-15, #000495-15, resulted in injury #020493-16, #025676-16, falls #013938-15, #015351-16, and #020118-16, #015349-16, #027580-16, #027852-16, #028705-16, other issues #016540-16, and complaints intakes #027562-15, #034402-15, and #017495-15.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Nursing (DON), Assistant Administrator, Building Service Manager, Nurse Managers, Registered Dietitian (RD), Physiotherapist (PT), Occupational Therapist (OT), Resident Assessment Instrument (RAI) Coordinator, Social Workers (SW), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Recreation and service staff, Environmental Staff, Personal Care Aides (PCAs), Private Sitter, President of the Residents' Council, active members of the Family Council, Residents, and Family Members.

During the course of the inspection, the inspectors conducted observations of residents and home areas, medication administration, infection prevention and control practices, reviewed clinical health records, staffing schedules/assignments, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **5 WN(s)**
- **4 VPC(s)**
- **1 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all residents are protected from physical abuse.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, subject to subsection (2), the use of physical force by a resident that causes physical injury to another resident.

The home submitted a Critical Incident (CI) report in 2015, indicating that resident #024 had bitten resident #023 and caused injury.

The home submitted a subsequent CI report in a next month in 2015, indicating that resident #024 had caused a physical injury to resident #025.

Resident #024 was admitted to the home with an identified health condition. A review of resident #024's clinical records identified the resident as having responsive behaviours that included both physical and verbal aggression.

Interviews with RN #122, RN #123, RPN #126, PCAs #124 and #139 indicated that resident #024 was "very territorial" of the television (TV) room. Staff indicated that resident #024's responsive behaviours would be triggered by other residents entering the TV room. The staff further indicated that resident #024 would also become both physically and verbally aggressive to co-residents in the common area often triggered by noise and crowded areas. The staff indicated that they responded to resident #024's physical and verbal aggression by redirecting co-residents away from resident #024, which was not always possible for wandering co-residents, or for those wanting to use the TV room.

A review of resident #024's progress notes revealed 13 documented incidents of both verbal and physical aggression toward co residents. Of the 13 incidents, two resulted in physical injury to both residents #023 and #025 and as follows:

Record review and interviews with both RN #122 and #123 indicated that, resident #024 had been sitting in his/her wheelchair in the common area. RN #123 indicated that he/she had heard a loud scream from the common area and had found resident #023 bleeding from an injury caused by resident #024. Both RN's indicated that resident #023 may have walked by or touched resident #024 causing resident #024 to physically respond.

Record review and interviews with RN #122 and PCA #124 indicated that PCA #124 heard yelling from inside an identified home area and when he/she entered the room had found resident #024 holding resident #025 in a choke position. The PCA had to call extra

staff to remove resident #024's arm from resident #025's neck. Resident #025 sustained an injury. RN #122 and PCA #124 further indicated that resident #025 had only been admitted to the home three days prior to the incident. Both staff indicated that resident #025 had been observed to wander the home area, and that the resident would have entered the TV room not knowing that resident #024 was territorial of the TV room and may respond physically. There were no interventions put in place to keep residents safe other than occasional monitoring. Resident #024 was sent to hospital for assessment.

Interviews with DOC, RN's #122, #123, RPN #126, and PCA #124 all indicated that both resident #023 and #025 had been injured by resident #024's physical aggression and confirmed that both residents were the recipients of physical abuse. [s. 19. (1)]

2. A review of CI report revealed that in 2014, resident #041 was pulling a chair in the hallway to the nursing station. Resident #047 became upset because of it and deliberately drove his/her wheelchair and hit the chair being pulled by resident #041 causing resident #041 to fall and sustain an injury. Resident #041 was sent to the hospital for further assessment.

A review of resident #047's written care plan revealed that the resident was physically abusive to other residents using his/her wheelchair to push residents and the resident was required to ask for assistance to remove residents who are in his/her way.

A review of 2015, progress notes revealed that there was some documentation about staff reminding resident about the agreement. There were a few incidents documented where the resident hit the staff.

A review of resident #041, and #047's progress notes revealed that on an identified day, PCA #118 witnessed resident #047 talking to resident #041 while moving in his/her wheelchair toward resident #041. Resident #047 used his/her wheelchair to strike the chair being pulled by resident #041, causing resident #041 to fall. Police was called by the home in response to this incident of abuse. Resident #047 became very upset, uncooperative, verbally aggressive, shouting at staff and police officers and denied hitting resident #041.

Interview with resident #041 was not completed as the resident was discharged from the home.

A review of the contract between resident #047 and the home revealed that as a result of

incident certain conditions were applied.

Interview with PCA #118 revealed that he/she witnessed the above mentioned incident. Resident #047 was upset and hit resident #041 and with his/her wheelchair. Resident #047 was attempting to hit resident #041 again and it was prevented by PCA #118. PCA #118 indicated that resident #041 had sustained an injury and had to go to the hospital.

Interview with RN #121 revealed that resident #047 had physically abusive behaviour and he/she hit residents using his/her wheelchair in the past.

Interview with RN #119, Nurse Manager #102, and Social Worker #120 revealed that resident #047 was physically abusive to resident #041 during the above mentioned incident.

The severity of the non-compliance and the severity of the harm were actual harm.

The scope of the non-compliance was isolated.

A review of the Compliance History revealed that there was no history of non-compliance related to the Long-Term Care Homes Act, 2007, s. 19. (1). [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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. (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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care set out clear directions to staff and others who provided direct care to the resident.

The home submitted a CI report in 2015, indicating that resident #024 caused an injury to resident #023.

The home submitted a subsequent CI report next month in 2015, indicating that resident #024 had caused a physical injury to resident #025.

Resident #024 was admitted to the home with an identified health condition. A review of resident #024's clinical records identified the resident as having responsive behaviours that included both physical and verbal aggression.

Interviews with RN #122, RN #123, RPN #126, PCA's #124 and #139 indicated that resident #024 was "very territorial" of the television (TV) room. Staff indicated that resident #024's responsive behaviours would be triggered by other residents entering the

TV room as the resident perceived this room as his/her own. The staff further indicated that resident #024 would also become both physically and verbally aggressive to co-residents in the common area often triggered by noise and crowded areas.

A review of resident #024's progress notes in 2015, revealed 13 documented incidents of both verbal and physical aggression toward co residents. Of the 13 incidents, two resulted in physical injury to both residents #023 and #025. All incidents took place in and around an identified room and common lounge area.

A review of resident #024's written plan of care from the time of his/her admission indicated that the resident had been identified with responsive behaviours. The written plan of care included interventions to respond to the above mentioned behaviours that included, removing the resident when the behaviour is unacceptable, provide a consistent care giver and allow the resident to wander in a safe place. The written plan of care did not reveal any indication that resident #024 was "territorial" or that loud areas such as the common area would trigger both verbal and physical aggression toward co-residents. The written plan of care did not include any directions to staff on how to respond to resident #024's verbal and physical aggression triggered by his/her territorialism.

Interviews with the DOC and RN #122 confirmed that resident #024 had been identified with territorial behaviours and that the resident's ownership of the TV room had posed an actual risk to other residents that have entered or may have entered the room. Both the DOC and RN #122 further confirmed that resident #024's written plan of care had not been reflective of the resident's territorial behaviours and as a result did not include any staff direction. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

A review of the CI revealed that in 2016, PCA #108 assisted resident #044 to bed and reported to RN #110 that the resident had blue discoloration and swelling on a specified body part. During assessment, the resident complained about pain. The resident was unable to identify when pain was started. No staff heard the resident complaining of pain in earlier shift. The resident was sent to hospital, diagnosed with a fracture scheduled for an appointment with the Fracture Clinic.

A review of the resident's written plan of care revealed that the resident was at high risk for falls.

A review of the home's investigation revealed that PCA #108 was assigned to the resident, he/she assisted the resident for toileting. During toileting, when the resident was holding a bar and was in the standing position, next to the toilet, the resident lowered his/her body to the floor. PCA #108 indicated that the resident was light in weight and PCA #108 was able to transfer the resident to the wheelchair and to the bed and his/her brief was changed. PCA #108 confirmed during the investigation that he/she did not report to the nurse because he/she thought it was not considered a fall.

Interview with PCA #108 revealed that when he/she assisted the resident for toileting the resident dropped his/herself down on the floor while the resident was holding a bar close to the toilet. There was a wheelchair behind the resident and a commode was left behind the wheelchair. PCA #108 turned back to get the commode and the resident dropped the bar and his/her body was dropped to the floor. PCA #108 transferred the resident up on the wheelchair and on the bed and changed the resident's brief. The resident complained about leg pain and it was communicated to the nurse by PCA #108. The nurse told the PCA that the resident received his/her pain medication and he/she should be OK. PCA #108 confirmed that he/she did not report the incident in the washroom to the nurse and that it was his/her mistake.

Interview with RN # 110, revealed that he/she transferred the resident to the hospital after the resident was identified with skin discoloration and swelling.

Interview with Nurse Manager #112 revealed that PCA #108 should have reported the incident to the registered staff, so registered staff could have completed an assessment in the earlier shift. [s. 6. (4) (a)]

3. 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 review of resident #043's plan of care revealed that the resident is high risk for falls, as evidenced by 10 falls in 2016. The resident should be wearing specified protective items all the time.

Observation on an identified day in 2016 revealed that the resident was sitting in front of

the nursing station without the specified protective items.

Interview with PCA #117 revealed that the resident always stays in the wheelchair and does not walk therefore he/she did not put the specified protective items on the resident in the morning. PCA #117 checked the care plan and confirmed that the resident should wear the specified protective items all the time. He/she immediately took the resident in the room and put the specified protective item on. The inspector did not see the resident resistive or in any discomfort because of the specified protective items.

Interview with PCA #105 revealed that he/she found the resident not always wearing specified protective items, at start of the night shift.

Interview with RN #115 revealed that the resident should wear specified protective items all the time as indicated in the care plan.

Interview with Nurse Manager #102 and #113 revealed that PCA should follow the care plan and nurse on the floor is required to ensure that the care plan is followed. Resident #043 has a history of falls and is at high risk for falls, therefore he/she should wear the specified protective items all the time to prevent injuries as indicated in the plan of care. [s. 6. (7)]

4. A review of CI report revealed that in 2016, resident #042 was found lying on the floor in the hallway, yelling for help. The resident was assessed and sustained injury. The resident refused to get up from the chair to walk. The resident cried out during assessment by the nurse and refused for range of motion. The resident was transferred to the hospital and diagnosed with fracture.

A review of the clinical record revealed that resident was non-interviewable due to cognitive impairment.

A review of the resident's written care plan revealed that the resident was at high risk for the falls, and should be wearing specified protective items all the time, to prevent injuries.

A review of the progress note made on an identified day revealed that the social worker and Nurse Manager #102 called the family member and informed them that the resident was wearing specified protective items prior to the fall. Staff changed the resident and removed soiled specified protective items and placed it in the washing machine on the unit, and could not find other specified protective item.

Interview with PCA #103 revealed that he/she did not remember if the resident was wearing a specified protective item at the time of the fall.

Interview with RN #146 revealed that the resident's specified protective item was placed in the washing machine and another specified protective item was unavailable. As per the care plan, the resident should be wearing a specified protective item to prevent an injury during a fall. [s. 6. (7)]

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,
- the written plan of care sets out clear directions to staff and others who provide direct care to the resident,
- the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, and
- the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: 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 the skin care plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A review of CI report revealed that in 2015, an identified PCA notified to the charge nurse that resident #003's new alteration in skin integrity on an indemnified body area during the shower. The charge nurse completed the assessment and treatment was initiated.

A review of the incident and home's investigation notes revealed that initially RPN #114 became aware of the resident's wound while approximately 1-2 weeks before an identified day but forgot to initiate appropriate wound assessment and treatment. As a result the wound progressed. Initially, RPN #114 assessed and applied dressing to the wound at the time, however admitted during the home's investigation that he/she forgot to report and document the resident's alteration in skin integrity. As a result the alteration in skin integrity went unnoticed and untreated for a number of days. Later on, the home identified the resident's alteration in skin integrity and treatment was initiated from that point on.

Record review of the home policy on "Skin Care and Wound Prevention and Management RC 0518- 02" indicated that "If any evidence or risk of altered skin integrity, for all alteration in skin integrity s, skin tears or wound, completes a Brandon Scale. Implement immediate treatment and interventions to reduce/eliminate pressure, reduce/relieve pain, prevent infection and promote healing. Based on the result of assessment, initiate referrals for skin care coordinator, Physician, PT/OT and dietitian for altered skin integrity including alteration in skin integrity s, skin tears or wounds." The policy also states " based on the assessment and risk, update care plan, inform resident/SDM regarding the next steps in the treatment plan and obtain consent to treatment; document verbal consent for treatment plan in progress note."

Interview with RPN #114, confirmed that she/he was trained on wound management policy and well aware of the home's wound care policy and practice expectation when an alteration in skin integrity is reported. She /he re-iterated that it is the home's expectation to always assess, document and report any alteration in skin integrity and then initiate treatment as needed. RPN #114 stated that in this particular case, the incident "slipped" out of her/his mind and forgot to document, report and follow up with the wound. RPN #114 confirmed that it is the homes expectation that registered staffs assess, treat, document and report every alternation in skin integrity and initiate treatment accordingly.

He/she confirmed that he/she did not follow the skin and wound policy of the home when the alteration in skin integrity was identified and reported to him/her.

Interview with the Nurse Manager #113 confirmed that the home's policy on "Skin care and wound prevention and management" specifies the steps, direction and the necessary measures for staff to follow for any wound. Staff are educated on the policy and are always expected to follow the policy all the time. Nurse Manager #113 confirmed that in the above mentioned incident RPN # 114 had failed to implement and follow the skin and wound policy of the home and he/she was disciplined. [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 that the skin care plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #4: 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 the resident exhibiting altered skin integrity, including skin breakdown, alteration in skin integrity, skin tears or wounds, received 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 CI report revealed that in 2015, an identified PCA notified to the charge nurse that resident #003's new alteration in skin integrity on an identified body area during the shower. The charge nurse completed the assessment and treatment was initiated.

A review of the incident and home's investigation notes revealed that initially RPN #114 became aware of the resident's wound approximately 1-2 weeks before an identified day but forgot to initiate appropriate assessment and treatment. As a result the alteration in skin integrity progressed. Initially, RPN #114 assessed and applied dressing to the wound at the time, however admitted during the home's investigation that he/she forgot to report and document the resident's alteration in skin integrity. As a result the alteration in skin integrity went unnoticed and untreated for a number of days. Later on, the home identified the resident's alteration in skin integrity as stage III and treatment was initiated from that point on.

Interview with RPN#114 confirmed that he/she failed to assess and document the alteration in skin integrity using a clinically appropriate tool. He/she stated that the alteration in skin integrity was reported to him/her by a PCA and he/she applied dressing at the time but forgot to use the Branden Scale Assessment Tool and to document the assessment into progress notes. RPN #114 stated that "It slipped out of my mind" and failed to communicate with other team members. As a result the wound went untreated for a number of days. RPN #114 stated that it is the expectation of the home to use the specified clinically appropriate assessment tool, document and treat any alteration in skin integrity wound that is reported by staff.

A review the home policy "Skin Care and Wound Prevention and Management RC 0518-02" indicated that "If any evidence or risk of altered skin integrity, for all alteration in skin integrity s, skin tears or wound, completes a Braden Scale. Implement immediate treatment and interventions to reduce/eliminate pressure, reduce/relieve pain, prevent infection and promote healing."

Interview with Nurse Manager #113 confirmed that RPN #114 had failed to use the clinically appropriate tool to assess and document when the alteration in skin integrity was initially reported by the PCA. As a result, the wound was left untreated and progressed. Nurse Manager #113 confirmed that it is the home's expectation to have every wound/ulcer to be assessed using a Branden Scale Assessment Tool, document and communicate to the interdisciplinary team. [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 to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive 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 #5: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, (b) identifying and implementing interventions.

The home submitted a CI report in 2015, indicating that resident #024 had caused an

injury to resident #023.
The home submitted a subsequent CI report next month in 2015, indicating that resident #024 had caused a physical injury to resident #025.

Resident #024 was admitted to the home with an identified health condition. A review of resident #024's clinical records identified the resident as having responsive behaviours that included both physical and verbal aggression.

Interviews with RN #122, RN #123, RPN #126, PCA's #124 and #139 indicated that resident #024 was "very territorial" of the television (TV) room. Staff indicated that resident #024's responsive behaviours would be triggered by other residents entering the TV room as the resident perceived this room as his/her own. The staff further indicated that resident #024 would also become both physically and verbally aggressive to co-residents in the common area often triggered by noise and crowded areas.

A review of resident #024's progress notes for 2015, revealed 13 documented incidents of both verbal and physical aggression toward co residents. Of the 13 incidents, two resulted in physical injury to both residents #023 and #025. All incidents took place in and around the TV/Montessori room and common lounge area.

A review of resident #024's written plan of care from the time of his/her admission did not reveal any indication that resident #024 was "territorial" or that loud areas such as the common area would trigger both verbal and physical aggression toward co-residents. Interventions to minimize the triggers and manage the aggressive behaviour were not identified.

Interviews with the DOC and RN #122 confirmed that resident #024 had been identified with territorial behaviours and that the resident's ownership of the TV room had posed an actual risk to other residents that have entered or may have entered the room. Both the DOC and RN #122 further confirmed that resident #024's written plan of care had not been reflective of the resident's territorial behaviours, nor did it contain interventions to minimize the risk of altercation between resident #024 and the other residents if/when they would enter the TV room. RN #122 stated that resident #024 had been a risk to other residents and that there had been no interventions implemented to respond or minimize the risk to other residents, other than keeping other residents away from the TV room, which was not always possible. [s. 54. (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 that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, (b) identifying and implementing interventions, to be implemented voluntarily.

Issued on this 25th day of November, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NITAL SHETH (500), DEREGE GEDA (645), VALERIE JOHNSTON (202)
Inspection No. / No de l'inspection :	2016_413500_0011
Log No. / Registre no:	027311-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 25, 2016
Licensee / Titulaire de permis :	City of Toronto 55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6
LTC Home / Foyer de SLD :	CUMMER LODGE 205 CUMMER AVENUE, NORTH YORK, ON, M2M-2E8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Leah Walters

To City of Toronto, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

Upon receipt of this order:

1. The licensee shall develop, implement and submit a plan that will ensure all residents residing on a specified home area are protected from physical abuse, elicited by resident #024 and #047's physically responsive behaviours.

The plan is to include the required tasks, the person responsible for completing the tasks and the time lines for completion. The plan is to be submitted to nital.sheth@ontario.ca by December 15, 2016.

2. Within one week of receipt of this order, conduct a meeting between management and direct care staff for the specified home area, to discuss roles and responsibilities in communicating strategies in dealing with the residents' physically abusive behaviours. Prepare a list of the attendees and the date; copy of the agenda and written strategies.

3. The meeting shall allow direct care staff opportunities to collaborate in the development and implementation of written strategies, including techniques and interventions to meet the needs of resident #024 and #047's physically responsive behaviours. The written strategies must include strategies, techniques and interventions, to prevent, minimize or respond to the risks associated with physical abuse to other residents residing on the specified home area.

Grounds / Motifs :

1. The licensee has failed to ensure that all residents are protected from physical abuse.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, subject to subsection (2), the use of physical force by a resident that causes physical injury to another resident.

A review of CI report revealed that in 2014, resident #041 was pulling a chair in the hallway to the nursing station. Resident #047 became upset because of it and deliberately drove his/her wheelchair and hit the chair being pulled by resident #041 causing resident #041 to fall and sustain an injury. Resident #041 was sent to the hospital for further assessment.

A review of resident #047's written care plan revealed that the resident was physically abusive to other residents using his/her wheelchair to push residents and the resident was required to ask for assistance to remove residents who are in his/her way.

A review of 2015, progress notes revealed that there was some documentation about staff reminding resident about the agreement. There were a few incidents documented where the resident hit the staff.

A review of resident #041, and #047's progress notes revealed that on an identified day, PCA #118 witnessed resident #047 talking to resident #041 while moving in his/her wheelchair toward resident #041. Resident #047 used his/her wheelchair to strike the chair being pulled by resident #041, causing resident #041 to fall. Police was called by the home in response to this incident of abuse. Resident #047 became very upset, uncooperative, verbally aggressive, shouting at staff and police officers and denied hitting resident #041.

Interview with resident #041 was not completed as the resident was discharged from the home.

A review of the contract between resident #047 and the home revealed that as a result of incident certain conditions were applied.

Interview with PCA #118 revealed that he/she witnessed the above mentioned incident. Resident #047 was upset and hit resident #041 and with his/her wheelchair. Resident #047 was attempting to hit resident #041 again and it was prevented by PCA #118. PCA #118 indicated that resident #041 had sustained an injury and had to go to the hospital.

Interview with RN #121 revealed that resident #047 had physically abusive behaviour and he/she hit residents using his/her wheelchair in the past.

Interview with RN #119, Nurse Manager #102, and Social Worker #120 revealed that resident #047 was physically abusive to resident #041 during the above mentioned incident. (500)

2. The home submitted a Critical Incident (CI) report in 2015, indicating that resident #024 had bitten resident #023 and caused injury.

The home submitted a subsequent CI report in a next month in 2015, indicating that resident #024 had caused a physical injury to resident #025.

Resident #024 was admitted to the home with an identified health condition. A review of resident #024's clinical records identified the resident as having responsive behaviours that included both physical and verbal aggression.

Interviews with RN #122, RN #123, RPN #126, PCAs #124 and #139 indicated that resident #024 was "very territorial" of the television (TV) room. Staff indicated that resident #024's responsive behaviours would be triggered by other residents entering the TV room. The staff further indicated that resident #024 would also become both physically and verbally aggressive to co-residents in the common area often triggered by noise and crowded areas. The staff indicated that they responded to resident #024's physical and verbal aggression by redirecting co-residents away from resident #024, which was not always possible for wandering co-residents, or for those wanting to use the TV room.

A review of resident #024's progress notes revealed 13 documented incidents of both verbal and physical aggression toward co residents. Of the 13 incidents, two resulted in physical injury to both residents #023 and #025 and as follows:

Record review and interviews with both RN #122 and #123 indicated that, resident #024 had been sitting in his/her wheelchair in the common area. RN #123 indicated that he/she had heard a loud scream from the common area and had found resident #023 bleeding from an injury caused by resident #024. Both RN's indicated that resident #023 may have walked by or touched resident #024 causing resident #024 to physically respond.

Record review and interviews with RN #122 and PCA #124 indicated that PCA #124 heard yelling from inside an identified home area and when he/she entered the room had found resident #024 holding resident #025 in a choke position. The PCA had to call extra staff to remove resident #024's arm from resident #025's neck. Resident #025 sustained an injury. RN #122 and PCA #124 further indicated that resident #025 had only been admitted to the home three days prior to the incident. Both staff indicated that resident #025 had been observed to wander the home area, and that the resident would have entered the TV room not knowing that resident #024 was territorial of the TV room and may respond physically. There were no interventions put in place to keep residents safe other than occasional monitoring. Resident #024 was sent to hospital for assessment.

Interviews with DOC, RN's #122, #123, RPN #126, and PCA #124 all indicated that both resident #023 and #025 had been injured by resident #024's physical aggression and confirmed that both residents were the recipients of physical abuse.

The severity of the non-compliance and the severity of the harm were actual harm.

The scope of the non-compliance was isolated.

A review of the Compliance History revealed that there was no history of non-compliance related to the Long-Term Care Homes Act, 2007, s. 19. (1). [s. 19. (1)] (202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 27, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 25th day of November, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Nital Sheth

Service Area Office /
Bureau régional de services : Toronto Service Area Office