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 8, 15, 2016	2016_516650_0004	020034-16	Critical Incident System

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

KAREN MILLIGAN (650)

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 27, 28, 29, October 3, 4, 5, 6, 7, 2016.

During the course of the inspection, the inspector: reviewed clinical records, reviewed home's policies related to abuse and neglect, safe lifts and transfers, training records related to mechanical lifts, and conducted observations of staff to resident interactions, and lifts and transfers.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Nursing, Nurse Manager, Registered Nurses, Personal Care Aides, Medical Director, Substitute Decision Maker.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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. (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 care set out in the plan of care is provided to the resident as specified in the plan.

The home submitted a Critical Incident System Report on a specified date which indicated that family of resident #001 reported that a staff member neglected resident #001 by making them wait 30 minutes for assistance with toileting.

Review of the written plan of care for a specified period, indicated that resident #001 was totally dependent on staff for transfers and requires the use of a lift and the assistance of two staff to transfer. Review of the written plan of care also indicated that resident #001 was at high risk for falls and for this reason also requires two staff to assist with transfers using a lift.

Interview with Personal Care Aide (PCA) #100 revealed that he/she was aware that resident #001 required two person assistance and an identified lift to transfer. PCA #100 stated that on a specified date, when resident #001's substitute decision-maker (SDM) threatened to report him/her for neglect, he/she transferred resident #001 using the lift by him/herself. Interview with the Director of Nursing (DON) confirmed that PCA #100 did not follow resident #001's plan of care and therefore the care set out in resident #001's plan of care had not been provided to the resident as specified in the plan. [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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff used safe transferring and positioning devices or techniques when assisting residents.

The home submitted Critical Incident System Report on a specified date which indicated that the family of resident #001 reported a staff member neglected a resident by making them wait 30 minutes for assistance with toileting.

Review of the written plan of care for a specified period, revealed that resident #001 required the use of a lift with two staff to assist with transfers. A review of the home's Mechanical Lifting Device policy, NU-0606-00 dated January 4, 2016, indicates that "all mechanical lifts require two caregivers to operate".

Staff interview with PCA #100 indicated that on a specified date, resident #001's SDM requested that the resident be transferred to the toilet so the SDM could apply lotion to the resident. PCA #100 indicated that he/she told the SDM that he/she would transfer resident #001 when he/she finished serving nourishments to the other residents. PCA #100 stated that resident #001's SDM yelled at him/her and threatened to report him/her to management. PCA #100 further stated that he/she stopped providing nourishments to the other residents and obtained an identified lift and transferred resident #001 to the toilet by him/herself.

Interview with the DON confirmed that PCA #100 did not follow the home's Mechanical Lifting Device policy or the resident's plan of care, and further confirmed that PCA #100 did not use safe transferring and positioning devices or techniques when assisting resident #001. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secured and locked.

On a specified date, the inspector observed two bottles of lotion in resident #001's room; one on the bathroom counter and one on the dresser in his/her bedroom. Both bottles had the resident's name on it, written in black marker.

On a specified date, RN #106 confirmed that two bottles of lotion were in resident #001's room and further confirmed that they should be stored in the locked treatment cart. [s. 129. (1) (a)]

Issued on this 9th day of December, 2016

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

Original report signed by the inspector.