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
Apr 5, 2017	2017_370649_0007	033243-16, 033817-16, 034018-16	Complaint

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

JULIEANN HING (649)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 9, 10, 13, 14, 16, 17, 20, 21, 24, 28, and 30, 2017.

The following intakes were inspected concurrently with this inspection:
Log #033243-16 related to Residents' Bill of Rights, whistle-blowing protection, and plan of care.
Log # 033817-16 related to safe storage of drugs, whistle-blowing protection, dealing with complaints and plan of care.
Log # 034018-16 related to a licensee investigation, administration of drugs, and Residents' Bill of Rights.

During the course of the inspection, the inspector(s) spoke with the Medical Director, Acting Director of Nursing (A-DON), Counsellor, Resident Assessment Instrument (RAI) Coordinator, Registered Dietitian (RD) Nurse Managers (NM), Registered Nurses (RN), Registered Practical Nurses (RPN), Practical Care Aides (PCA) and family members.

During the course of the inspection, the inspector toured the home, reviewed health records, reviewed the home's staff training records, staff schedules, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Medication
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents were fully respected and promoted: Every resident has the right to, have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

On an identified date in December 2016, a complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) action line that there was a privacy breach of a resident #066.

Interview with resident #062's substitute decision maker (SDM) revealed that during a telephone conversation with staff #139 and staff #188 on an identified date in November 2016, they had disclosed that resident #066 was being referred for an identified assessment.

Interview with staff #139 revealed that he/she had a conversation on an identified date in November 2016, with resident #062's SDM and had revealed that resident #066 was being referred for an identified assessment.

Staff #188 was not available for an interview during the course of this inspection.

Interview with acting director of nursing (A-DON) #126 revealed that resident #066's personal health information records were not kept confidential in accordance with the Personal Health Information Protection Act, 2004. [s. 3. (1) 11. iv.]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 7. Nothing in this Act authorizes a licensee to assess a resident's requirements without the resident's consent or to provide care or services to a resident without the resident's consent. 2007, c. 8, s. 7.

Findings/Faits saillants :

1. The licensee has failed to ensure that consent was obtained prior to the provision of care. Nothing in this Act authorizes a licensee to assess a resident's requirements without the resident's consent or to provide care or services to a resident without the

resident’s consent.

On an identified date in December 2016, a complaint was submitted to the MOHLTC action line that consent had not been obtained from the SDM for a medication order.

Record review of the physician order revealed that a medication had been ordered on an identified date in November 2016 for resident #062.

A review of the progress notes and the physician orders did not indicate that consent had been obtained from resident #062's SDM for the medication ordered.

Interview with Registered Nurse (RN) #106 revealed that he/she had not advised resident #062’s SDM's prior to processing the medication order and according to the medication administration record (MAR) resident was administered the medication on an identified date in November 2016.

Interview with resident #062's SDM revealed that he/she had spoken with the medical director #138 on an identified date in November 2016, related to certain concerns but had not consented during this conversation to any treatment and was unaware that this medication had been ordered by the medical director.

Interview with the medical director #138 revealed that he/she had spoken with the resident’s SDM and it was upon their request that the medication had been ordered. The medical director further revealed that there was no progress note of this conversation or consent for this treatment from the SDM.

Interview with staff #139 revealed that it is the home’s practice that if there is a new medication or a change in medication direction usually the doctor or the nurse processing the order will inform the family. Staff further revealed that sometimes the doctor needs to explain to the family the rationale for the medication and the doctor will communicate to the nurse if he/she had spoken to the family.

Interview with the acting A-DON #126 revealed that it is an expectation that the doctor will talk to the resident or call the family or the registered nurse will call the family to obtain consent. [s. 7.]

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 secure and locked.

On an identified date in December 2016, a complaint was submitted to the MOHLTC action line that a bottle of prescription medication had been found at resident #062's bedside table in his/her room.

Interview with practical care aides (PCA) #119 revealed that he/she had used the prescription medication with resident #065 during care. PCA further stated that he/she had gone to see resident #062 when he/she learned that the resident was unwell. PCA does not recall leaving the prescription medication in resident #062's room.

Interview with registered nurse (RN) #106 revealed that just before the end of the day shift resident #062's SDM had brought a bottle of prescription medication belonging to resident #065 and reported that it had been found on resident #062's bedside in his/her room. RN #106 revealed that the prescription medication was being stored in the treatment cart and locked when not in attendance.

Interview with the staff #139 revealed that the prescription medication should have been returned to the registered staff and locked in the treatment cart.

Interview with the A-DON #126 revealed that the prescription medication should have been returned by the PCA to the registered staff after it had been used. [s. 129. (1) (a)]

Issued on this 9th day of April, 2017

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

Original report signed by the inspector.