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 prévue le Loi de 2007 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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jul 13, 2017;	2017_493652_0004 (A1)	003639-17	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

Ontario

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Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

NATALIE MOLIN (652) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

A revision has been made to the compliance date. The new compliance date is September 8, 2017

Issued on this 13 day of July 2017 (A1)

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

Original report signed by the inspector.

Ontario

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

NATALIE MOLIN (652) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): February 14, 15, 16, 17, 20, 21, 22, 23, 24, 27, 28, and March 1, 2, 3, 6, 7, 8, 9, 10, 13, 14, 15, 16, 17, 20, 21, 22, 23, and 24, 2017.

The following critical incident (CI) inspections were conducted concurrently with the RQI:

Related to Duty to Protect: 035544-15, 036287-15, 030297-15, 028177-16, 034700-16, 012982-16, 013724-16, 008079-16, 015343-16, 034905-16, 032708-16, 023597-16, 021848-16, 004438-16, 021093-16, 008944-16, 022546-16, 028284-16, 020585-16, 029926-16, 029120-16, 033319-16, 015655-16, 021623-16, 007973-16, 000917-17, 002211-17, 001078-17

Related to Falls Prevention and Management: 032148-16, 032946-16, 034405-16, 000585-17

Related to Plan of Care: 030297-15, 020585-16, 033753-16

Related to Duty to Report: 020585-16

Related to Safe and Secure Home: 016540-16

The following Complaint intakes were inspected concurrently with this RQI:

Related to Fall Prevention and Management: 034443-16

Related to Personal Support Services: 024796-16

Related to Duty to Protect: 029566-16

Related to Plan of Care: 000321-17

The follow up order to the following intake was conducted concurrently with the RQI: 000061-17

The following complaint inspections were conducted concurrently with the RQI: 029566-16 (related to abuse)

During the course of the inspection, the inspector(s) spoke with the assistant administrator, director of nursing (DON), acting director of nursing (ADON), nurse managers (NM), complementary care assistant, recreation service

assistant, medical director, attending physicians, food service workers, registered dietitian (RD), registered nursing staff, practical care aides (PCAs), behaviour support outreach team, residents, substitute decision makers (SDMs), Residents' Council President and social worker/Family Council Representative and family members.

During the course of the inspection, the inspector(s) conducted a tour of the home and observed meal service, medication administration, staff to resident interactions and the provision of care, and reviewed health records, staff training records, meeting minutes for Residents’ Council and Family Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

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

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Snack Observation

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

- **5 WN(s)**
- **2 VPC(s)**
- **3 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. 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 residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

1. Record review of CI of an identified date in 2017 revealed resident #032 reported that a practical care aide (PCA) was abusive to him/her when he/she requested care and assistance on the night shift on this same date.

Record review of resident #032's written plan of care revealed that the resident required extensive physical assistance from one staff for transfers and walking.

Interview with resident #032 revealed that on January 2017, he/she requested PCA #183 to assist him/her with identified care. PCA #183 responded to resident #032 in a rude manner and stated that the resident could do everything for his/herself.

Resident #032 requested PCA #183 to pass an item and PCA #183 asked the resident why he/she wanted the item, and the resident revealed that he/she wanted to go to the nursing station .The resident revealed that PCA #183 then shut the door to his/her room and offered him/her no assistance. The resident revealed that this made him/her very upset and was up all night because of it. Resident #032 informed the registered practical nurse (RPN) #186 that he/she did not want PCA #183 to provide his/her care again.

Interview with RPN #186 revealed that resident #032 came to him/her at the nursing station that night and reported the encounter between the resident and PCA #183. The RPN #186 further revealed that the resident was upset by the incident.

Interview with nurse manager/acting director of nursing (NM/Acting DON) #126 revealed that PCA #183's behaviour in telling the resident that he/she did not require extensive assistance and not helping the resident, was unacceptable. He/she revealed that resident #032 was not protected from abuse. [s. 19. (1)]

2. Record review of CI of an identified date in 2016 revealed resident #033 reported that PCA #182 was abusive to him/her.

Interview with resident #033 revealed he/she shared a washroom with co-resident and on that particular day, he/she had overheard PCA #182 and his/her roommate speaking with raised voices. Resident #033 went to the washroom after PCA #182 and the co-resident exited, and observed that the washroom floor and toilet seat were wet, and dirty gloves were on the sink. The resident stated that this was unprofessional and went to report his/her concern to RN #135. PCA #182 approached resident #033, and questioned his/her actions. Resident #033

revealed PCA #182's questioning made him/her feel intimidated when the staff asked why he/she reported his/her concerns.

Interview with (RN) #135 revealed that on the day of the incident, resident #033 had approached him/her to go to his/her washroom to observe the environment, and RN #135 had observed that the floor was wet around the toilet, and observed the dirty gloves on the counter. RN #135 approached PCA #182 to inform the PCA that he/she should have cleaned the washroom as it was his/her assignment, and that the PCA had agreed.

The NM/Acting DON #126 revealed that resident #033 was not protected from verbal abuse by the staff. [s. 19. (1)]

3. Record review of CI of an identified date in 2016 revealed that RN #164 witnessed inappropriate touching of co-resident.

Resident #063 was admitted to the home from another LTCH on an identified date with an identified history of inappropriate touching of vulnerable residents. According to the Community Care Access Centre (CCAC) admission notes this behaviour was most likely to occur during scheduled breaks or when there were fewer staff on the unit and with residents who were in wheelchairs or broada chairs who were cognitively impaired.

Resident #064 was admitted to the home due to his/her responsive behaviour. At the time of the incident on an identified date, resident #064 had cognitive impairment.

Record review of resident #063's progress notes indicated on an identified date, at around 2130 hours resident #063 attempted to touch a co-resident but staff intervened and redirected the residents. A DOS monitoring every 30 minutes was initiated after the incident had occurred. The resident had been assessed by the occupational therapist (OT) who followed up with the team to assess the resident's behaviour and set behavioural goals.

Record review of resident #063's progress notes on an identified date, indicated that resident #063 attempted to touch resident #064 at around 1430 hours and RPN #171 intervened and redirected the residents and close monitoring continued. A review of resident #063's DOS monitoring on an identified date, indicated that resident had been awake most of the day shift, and there were no documentation

of the attempted behaviour on the DOS nor on the daily resident/staff communication report.

Interviews with RNs #164, #172, and #192 revealed that there had been no assessment or reassessment of resident #063 after both incidents on two identified dates. The RNs indicated that no other interventions were implemented other than the 30 minutes DOS monitoring that was started on an identified date, and resident #063 could be seen from the nursing station .

Both residents were discharged from the home.

Interviews with RNs #164, #172 and #192 revealed that resident #063 was admitted to the home with an identified responsive behaviour of inappropriate touching of co-residents when there is less staff around. Resident #063 will target residents who are vulnerable or cognitively impaired, in wheelchairs or broada chairs that could not defend themselves. The RNs further revealed that no responsive behaviours had been indicated on resident #063's 24 hour admission plan of care. A review of resident #063's progress notes and interviews with staff revealed that the only interventions in place were DOS monitoring after the first incident had occurred.

Interviews with NM/ADON #126 revealed that the residents were not protected from abuse of inappropriate touching by resident #063. [s. 19. (1)]

4. Record review of CI of an identified date revealed that resident #023 had an altercation with resident #021 which resulted in an injury to resident #021.

Resident #023 was admitted to the home on an identified date, from another LTCH. Resident #023 had many identified behaviours upon admission.

Review of the home's documentation revealed that resident #023 was involved in three resident to resident altercations in his/her nine days on the unit. Resident #023 was transferred to hospital on an identified date.

Two of these incidents involved resident #021. On an identified date, resident #023 grabbed resident #021. This incident occurred in the middle of the night when resident #021 was sleeping in a chair in the common area and resident #023 approached him/her and grabbed him/her and this caused an altercation between the two residents. No injuries were identified as a result of this altercation.

The second incident involving these two residents occurred on an identified date at 1455 hours which resulted in injury to resident #021. Following this incident resident #023 was transferred out to the hospital and did not return to the home.

Record review for resident #023 revealed that there was no initial, 24 hour care plan developed and identification of his/her behaviours which would identify risks to other residents.

Record review of resident #023's DOS monitoring further revealed that it was not always completed as per the resident's plan of care.

Record review further revealed that no new interventions were implemented for resident #023 to minimize the risk of altercations and potentially harmful interactions between and among residents.

Interview with the ADON #125 revealed that resident #021 had not been protected from abuse.

Record review of the progress notes dated on an identified date, revealed that the resident was to be put on DOS monitoring, and that staff were to monitor his/her whereabouts.

Record review of resident #023's progress notes on an identified date, revealed that the resident continued to wander around the unit and refused to settle and that he/she was put on one to one monitoring, the doctor was informed and this was to be endorsed to the day shift.

Record review of resident #023's progress notes made no further mention of this resident having one to one monitoring and interview with ADON #125 revealed that the resident was never put on one to one monitoring.

Interview with the ADON #125 revealed that there is no evidence to identify what interventions were in place at the time of the altercations, if new interventions were considered or if new interventions were implemented in an attempt to minimize the risk of altercations between residents. [s. 19. (1)]

5. Record review of CI of an identified date revealed that resident #023 had an altercation with resident #024 which resulted in an injury to resident #024.

Resident #023 was admitted to the home on an identified date, from another LTCH. Resident #023 had many identified behaviours upon admission towards co-residents and staff.

Record review of the home's documentation revealed that resident #023 was involved in four resident to resident altercations in his/her nine days on the unit. Resident #023 was transferred to hospital on an identified date.

Record review revealed that on an identified date, at 1400 hours resident #023 grabbed resident #024's ambulation equipment. This caused resident #024 to yell at resident #023. This altercation resulted in resident #024 falling to the floor and suffering an injury to an identified body part.

Record review for resident #023's progress notes revealed that there was no initial, 24 hour care plan developed for this resident and therefore no identification of his/her behaviours which would identify risks to other residents.

Record review of resident #023's DOS monitoring further revealed that it was not always completed as per the plan of care and specific to this incident, DOS monitoring was not completed for the times between 1130 hours and 1430 hours on an identified date.

Record review further revealed that no new interventions were implemented for resident #023 to minimize the risk of altercations and potentially harmful interactions between and among residents.

Interview with ADON #125 revealed that resident #024 had not been protected from abuse. [s. 19. (1)]

6. Record review of CI of an identified date in 2016 revealed RPN's #167 and #170 witnessed PCA #147 use inappropriate language towards resident #046 on this same date.

Record review of resident #046's progress notes revealed there was no documentation regarding this incident.

Record review of the home's investigation documents revealed RPNs #170 and #167 witnessed PCA #147 speaking inappropriately to resident #046 on an

identified date. The outcome of this investigation concluded with PCA #147 receiving disciplinary actions and transferred to another unit.

Interview with resident #046 revealed PCA #147 spoke inappropriately at him/her on an identified date, and reported he/she felt no ill effects of this incident.

Interviews with RPN's #170 and #167 revealed when the incident occurred on an identified date resident #046 was in the common area on the unit and PCA #147 was transferring a co-resident in the vicinity of resident #046 when they both witnessed PCA #147 using inappropriate language towards resident #046. RPNs revealed they did not witness or observe how this incident had started.

ADON #125 who were involved in the investigation was unavailable for an interview.

The severity of the non-compliance and the severity of the harm were actual as it relates to residents #032, #033, #021 and #024.The scope of the non-compliance was isolated. A review of the compliance history revealed that there was a Voluntary Plan of Corrective Action (VPC) issued in inspection #2016_168202_0020, dated November 2, 2016, and a compliance order issued in inspection 2016_413500_0011 on November 25, 2016. As a result of the severity, scope and the licensee'
s previous compliance history, a compliance order is warranted. [s. 19. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

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 staff use safe transferring and positioning devices or techniques when assisting residents.

Record review of CI of an identified date in 2016 revealed resident #038, had a fall and sustained an injury to an identified body part related to improper transferring and positioning techniques.

Record review of the resident #038's written plan of care on an identified date, revealed that he/she was at high risk for falls and required physical assistance of two or more staff to transfer the resident from bed to wheelchair. The resident used a mechanical lift for transfers. This written plan of care also revealed the resident required his/her wheelchair to be positioned to prevent the resident from falling.

Review of the home's investigation notes of the incident revealed that PCA #182 transferred resident #038 manually on his/her own, had not affixed the resident's foot rests on the wheelchair, had not positioned the resident's wheelchair, and left resident #038 in his/her room unattended while the PCA went to the morning report.

Interviews with PCA #140, RPNs #141, #169, and RN #135 revealed that resident #038 was a two-person transfer and used a mechanical lift and the proper set-up of the resident's wheelchair included the footrests for the resident. PCAs #140, #168, and RPNs #141 and #169, who were working on the shift that day, further revealed that PCA #182 did not ask them to assist with transferring resident #038 that morning.

Interviews with RPN #141 and RN #135 revealed that resident #038's wheelchair was not positioned and the footrests were not attached to resident #038's wheelchair when they arrived in the resident's room on an identified date.

Interview with NM/ADON #126 revealed that PCA #182 left resident #038, who was at high risk for falls, unattended in his/her room. The NM/ADON #126 further revealed that PCA #182 did not transfer and position resident #038 as specified in the resident's written plan of care, and the resident fell out of her wheelchair and sustained the above mentioned injury.

The severity of the non-compliance and the severity of the harm were actual. The scope of the non-compliance was isolated. A review of the Compliance history revealed that there was a Voluntary Plan of Corrective Action (VPC) issued in inspection #2016_516650_0004, dated September 27, 2016. As a result of the severity, scope, and the licensee's previous compliance history, a compliance order is warranted. [s. 36.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).

s. 24. (4) The licensee shall ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act. O. Reg. 79/10, s. 24 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care plan must identify any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks.

Record review of two CIs on identified dates revealed that resident #023 had been involved in three resident to resident altercations which resulted in injury to the co-residents.

Resident #023 was admitted to the home on an identified date, from another Long term care home.

Record review of the home's incident report revealed that on an identified date, resident #023 grabbed the ambulation equipment of resident #024 causing an altercation between the two residents and as a result of this altercation resident #024 fell to the floor and suffered an injury.

Record review of resident #023's progress notes on an identified date, revealed that resident #023 was to be put on the Dementia Observation System (DOS) monitoring, and that staff were to monitor his/her whereabouts.

Record review of the home's incident reports revealed that on an identified date, resident #023 grabbed resident #021.This incident occurred in the middle of the night when resident #021 was sleeping in a chair in the common area and resident

#023 approached him/her and grabbed him/her and this caused an altercation between the two residents. No injuries were identified as a result of this altercation.

Record review of the home's incident report revealed that on an identified date, at 1600 hours resident #023 tried to take an item from a co-resident and then punched the co-resident on an identified body part. No injuries were identified as a result of this altercation.

Record review of resident #023's progress notes on an identified date, revealed that he/she exhibit behaviours and that he/she was put on one to one monitoring, the doctor was informed and this was to be endorsed to the day shift.

Record review of resident #023's chart revealed that the initial, 24 hour plan of care had not been developed for this resident.

Record review of resident #023's progress notes made no further mention of resident #023 having one to one monitoring and could not identify that new interventions were implemented to minimize the risk of altercations and potentially harmful interactions between the residents.

Interview with the Acting Director of Nursing (ADON) #125 revealed that there was no care plan developed which identified any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks.

The severity of the non-compliance and the severity of the harm were actual.The scope of the non-compliance was isolated. A review of the compliance history revealed no previous non compliance. As a result of the severity and scope a compliance order is warranted. [s. 24. (2) 2.]

2. The licensee has failed to ensure that the care set out in the 24-hour admission care plan was based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement coordinator under section 44 of the Act.

Record review of CI of an identified date in 2016 revealed that RN #164 witnessed a resident inappropriately touching a co-resident while in the common area at around 1530hours.

Record review revealed that resident #063 was admitted on an identified date, and the 24-hour admission plan of care did not indicate that resident had any responsive behaviours related to inappropriate touching.

Interviews with RNs #164, #172 and #192 revealed that resident #063 was admitted from another LTCH with an identified history of inappropriate touching of co-residents. According to CCAC's admission notes these responsive behaviours were most likely to occur when there was less staff around and that resident #063 would target residents who were vulnerable or cognitively impaired and were in wheelchairs or broada chairs and could not defend themselves.

Interviews with RNs revealed that the resident was started on a 30 minute DOS monitoring on an identified date, after the incident on an identified date, when resident #063 attempted to touch another resident.

Record review of the daily resident/staff communication record and DOS monitoring indicated that there was no documentation of a second incident that had taken place on an identified date, when resident #063 attempted to touch resident #064.

Interviews with RNs revealed that there had been no assessment or reassessment of resident #063 after both incidents on two identified dates, and indicated that no other interventions were implemented.

Interview with acting NM/ADON #126 revealed that resident #063 should have been reassessed given the identified history of inappropriate touching from CCAC admission notes and when the incidents had occurred on an identified date, to ensure residents safety on the unit. [s. 24. (4)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 003

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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 fail to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

During the course of the inspection, resident #013 triggered related to low Body Mass Index (BMI) and weight loss.

Record review of resident #013's most recent Minimum Data Set (MDS) revealed that he/she experienced significant weight loss. Review of the resident's Nutrition Assessment on an identified date revealed that the resident had a low BMI and experienced a significant weight loss of 14 percent compared to over 30 days ago. Review of resident #013's written care plan revealed that resident #013 received a specified diet. Resident #013's written plan of care further revealed that he/she required extensive to total assistance for eating related to his/her diagnoses, and staff to feed resident for most of his/her meals.

Review of resident #013's current written plan of care for Activities of Daily Living (ADL) on an identified date, revealed that he/she wore dentures, and staff were to put resident #013's dentures on in the morning and remove in the evening.

Observation of resident #013 on an identified date, in his/her room revealed that he/she was provided a tray with an entrée of fried egg and toast, and that the resident was not wearing his/her dentures and no staff was in the resident's room to provide the assistance required.

Interview with PCA #110, who was assigned to resident #013 on an identified date, revealed that he/she had provided the resident with his/her tray and did not provide assistance with the meals and feeding the resident. PCA #110 further revealed that he/she had forgotten to put in the dentures for resident #013 that morning. PCA #110 mentioned that resident #013 was not on his/her regular assignment and was told by another PCA that the resident eats by him/herself. PCA #110 stated that he/she thought the resident needed limited assistance, and he/she did not stay with the resident for the meal. PCA #110 revealed he/she did not look at the resident's written plan of care for meals. Upon reviewing the resident's written plan of care, PCA #110 revealed that the resident required total assistance with one staff to feed him/her, and that the PCA had provided limited assistance and did not stay with the resident.

Interviews with RPN #116 and RPN #109 revealed that resident #013 required supervision and assistance with feeding at mealtimes, and that someone should be with him/her at meals, to remain with the resident the whole time during breakfast.The RPN also revealed that the PCAs were to look in the care binders to find information regarding the resident's care needs.

Interview with ADON #126 revealed that if the PCA was unsure about the resident's care, he/she was to review the residents' written plan of care before providing tray service for the resident to ensure the resident receives the right diet and assistance. The ADON further revealed that it was the home's expectation to have the PCAs report to the registered staff if the resident was not wearing his/her dentures and if they were uncomfortable. ADON #126 revealed that the care set out in the resident's plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

2. Ministry of Health and Long-Term Care (MOHLTC) received a complaint log #000321-17 on an identified date, regarding the provision of nutritional care to resident #039.

Record review of resident #039's written plan of care, medication administration record (MAR), and nutrition assessment on an identified date, revealed that he/she received modified diet. Resident #039's most recent MDS revealed he/she received a mechanically altered diet.

Observations of resident #039 on identified dates, revealed that he/she received and was eating a regular textured cookie at both afternoon nourishment times.

Interview with PCA #137 on an identified date, revealed that he/she had given resident #039 a regular cookie. PCA #137 revealed that he/she was aware that resident #039 was on a mechanically altered diet and modified cookies were available, but the PCA stated that the resident wouldn't have eaten the modified cookies, and he/she gave the resident a regular cookie instead.

Interviews with PCA #146 and RN #135 revealed that resident #039 is on a mechanically altered diet. RN #135 further revealed that the concern regarding the resident's ability to tolerate regular texture snacks had not been referred to the registered dietitian (RD).

Interview with RD #150 revealed that the home's expectation is that if a resident's plan of care requires his/her meals and snacks to be of a mechanically altered texture he/she should received that texture for meals and snacks. RD #150 further revealed that if the resident regularly refuses the snack, a referral should be made to the RD. The RD revealed that she did not received a referral regarding resident #039 refusing his/her snacks. RD #150 revealed that the cookies that the staff provided for the resident were of the regular texture, and that the resident should have received mechanically altered snacks. RD #150 and ADON #126 revealed that resident #039 did not receive his/her planned snack, as per his/her plan of care. [s. 6. (7)]

3. Record review of the CI of an identified date in 2015 revealed, resident #053 reported to the nurse that RPN #186 was trying to change the resident's clothes for bed and the resident refused. Resident #053 indicated during the investigation, staff #186 tried to persuade him/her to change and the resident did not like to be persuaded. Resident #053 yelled at staff #186 and got up from his/her bed and grabbed identified body parts of RPN #186 resulting in injury. RPN #186 tried to remove resident #053 from his/her body part and mentioned it took sometime for resident #053 to finally let go of him/her.The resident was later found to have injury however the history and cause of the injury were unable to be verified.

Record review of resident #053's progress notes on an identified date, revealed RPN #186 reported that when he/she approached the resident to provide care the resident displayed responsive behaviours. This note also mentioned that RPN #186 sustained an injury to an identified body part.

Record review of resident #053's progress notes on an identified date, (late entry

note) revealed resident #053 reported to the nurse that he/she refused to change his/her clothes before bed on an identified date.

Record review of resident #053's plan of care indicated if the resident verbalized that he/she prefers not to change staff need to respect the resident's wishes as per his/her plan of care.

Interview with staff #186 revealed an awareness of the resident's plan of care to re-approach the resident if the resident refuses to change clothes before bed. Staff #186 revealed he/she tried to verbally persuade the resident to change his/her clothes.

Interviews with PCA #179 and RPN #180 revealed resident #056 that staff are to respect the resident's wishes as per the plan of care.

Interview with resident #053 revealed he/she could not recall the events of this incident.

Interview with the NM/ADON #126 revealed staff #186 did not follow the plan of care for resident #053 and should not have tried to persuade the resident to change into his/her night clothes when he/she refused on more than one occasion. [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 #5: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

A review of the CI of an identified date in 2016 revealed an alleged staff to resident abuse occurred between resident #046 and PCA #147 on this same date at 2010hrs.The CI has identified that the MOHLTC after hours pager was not contacted about this incident and the first date and time of submission to the ministry occurred on an identified date.

Interviews with RPNs #167 and #170 revealed he/she witnessed PCA #147 using inappropriate language towards resident #046 on an identified date and immediately reported it to the RN.

Interview with RN #130 revealed that the process of handling any allegation of abuse is that staff report it to the manager. The home's investigation documents revealed the manager became aware of this allegation of abuse on an identified date, via email from RN #130

Interviews with the NM/ADON #126 and the Assistant Administrator (AA) revealed that the CI was submitted late and the expectation is that any allegations of abuse is immediately reported to the MOHLTC.

The AA contacted the DON #187 who was unable to provide information on why the CI was reported to the MOHLTC twenty four days after the incident occurred on an identified date. [s. 24. (1)]

2. Record review of CI of an identified date in 2017 revealed resident #032 reported that a PCA was verbally abusive to him/her when he/she requested care and assistance on the night shift. The incident was not reported to the MOHLTC until a later date.

Interview with the NM/ADON #126 revealed that the incident was abuse of resident #032, as described elsewhere in this report.The NM/ADON #126 further revealed that there was a miscommunication,and that the home was late in reporting this incident of abuse. [s. 24. (1)]

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 person who has reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director., to be implemented voluntarily.

Issued on this 13 day of July 2017 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : NATALIE MOLIN (652) - (A1)

Inspection No. / No de l'inspection : 2017_493652_0004 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 003639-17 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Jul 13, 2017;(A1)

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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 report the licensee shall prepare a plan to include but not limited to:

1.Train all staff on recognizing all forms of abuse, strategies to prevent abuse, the home's policy to promote zero tolerance of abuse. The training should also include:

i) Review of the findings of this compliance order as examples of abuse and neglect in the home and in relation to the definitions of abuse and neglect.

ii) Discussion about each individual staff person’s role in how each of these incidents of abuse and neglect could have been prevented.

iii) Discussion of each staff member's responsibility in resident centered approaches to care that demonstrate respect of residents and that are free from abuse and neglect.

2. Develop and implement a schedule to test and monitor staff compliance with the home's abuse policies.

This plan is to be submitted via email to inspector natalie.molin@ontario.ca by
June 29, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone, the licensee or staff in the home.

Record review of CI of an identified date in 2016 revealed RPN's #167 and #170 witnessed PCA #147 use inappropriate language towards resident #046 on this same date.

Record review of resident #046's progress notes revealed there was no documentation regarding this incident.

Record review of the home's investigation documents revealed RPNs #170 and #167 witnessed PCA #147 speaking inappropriately to resident #046 on an identified date. The outcome of this investigation concluded with PCA #147 receiving disciplinary actions and transferred to another unit.

Interview with resident #046 revealed PCA #147 spoke inappropriately at him/her on an identified date, and reported he/she felt no ill effects of this incident.

Interviews with RPN's #170 and #167 revealed when the incident occurred on an identified date resident #046 was in the common area on the unit and PCA #147 was transferring a co-resident in the vicinity of resident #046 when they both witnessed PCA #147 using inappropriate language towards resident #046. RPNs revealed they did not witness or observe how this incident had started.

ADON #125 who were involved in the investigation was unavailable for an interview.

(652)

2. Record review of CI of an identified date revealed that resident #023 had an altercation with resident #024 which resulted in an injury to resident #024.

Resident #023 was admitted to the home on an identified date, from another LTCH. Resident #023 had many identified behaviours upon admission towards co-residents and staff.

Record review of the home's documentation revealed that resident #023 was involved in four resident to resident altercations in his/her nine days on the unit. Resident #023 was transferred to hospital on an identified date.

Record review revealed that on an identified date, at 1400 hours resident #023 grabbed resident #024's ambulation equipment. This caused resident #024 to yell at resident #023. This altercation resulted in resident #024 falling to the floor and suffering an injury to an identified body part.

Record review for resident #023's progress notes revealed that there was no initial, 24 hour care plan developed for this resident and therefore no identification of his/her behaviours which would identify risks to other residents.

Record review of resident #023's DOS monitoring further revealed that it was not always completed as per the plan of care and specific to this incident, DOS monitoring was not completed for the times between 1130 hours and 1430 hours on an identified date.

Record review further revealed that no new interventions were implemented for resident #023 to minimize the risk of altercations and potentially harmful interactions between and among residents.

Interview with ADON #125 revealed that resident #024 had not been protected from abuse. [s. 19. (1)]
(618)

3. Record review of CI of an identified date revealed that resident #023 had an altercation with resident #021 which resulted in an injury to resident #021.

Resident #023 was admitted to the home on an identified date, from another LTCH. Resident #023 had many identified behaviours upon admission.

Review of the home's documentation revealed that resident #023 was involved in three resident to resident altercations in his/her nine days on the unit. Resident #023 was transferred to hospital on an identified date.

Two of these incidents involved resident #021. On an identified date, resident #023 grabbed resident #021. This incident occurred in the middle of the night when resident #021 was sleeping in a chair in the common area and resident #023 approached him/her and grabbed him/her and this caused an altercation between the two residents. No injuries were identified as a result of this altercation.

The second incident involving these two residents occurred on an identified date at 1455 hours which resulted in injury to resident #021. Following this incident resident #023 was transferred out to the hospital and did not return to the home.

Record review for resident #023 revealed that there was no initial, 24 hour care plan developed and identification of his/her behaviours which would identify risks to other residents.

Record review of resident #023's DOS monitoring further revealed that it was not always completed as per the resident's plan of care.

Record review further revealed that no new interventions were implemented for resident #023 to minimize the risk of altercations and potentially harmful interactions between and among residents.

Interview with the ADON #125 revealed that resident #021 had not been protected from abuse.

Record review of the progress notes dated on an identified date, revealed that the resident was to be put on DOS monitoring, and that staff were to monitor his/her whereabouts.

Record review of resident #023's progress notes on an identified date, revealed that the resident exhibit behaviours and that he/she was put on one to one monitoring,

the doctor was informed and this was to be endorsed to the day shift.

Record review of resident #023's progress notes made no further mention of this resident having one to one monitoring and interview with ADON #125 revealed that the resident was never put on one to one monitoring.

Interview with the ADON #125 revealed that there is no evidence to identify what interventions were in place at the time of the altercations, if new interventions were considered or if new interventions were implemented in an attempt to minimize the risk of altercations between residents. [s. 19. (1)]

(618)

4. Record review of CI of an identified date in 2016 revealed that RN #164 witnessed inappropriate touching of co-resident.

Resident #063 was admitted to the home from another LTCH on an identified date with an identified history of inappropriate touching of vulnerable residents. According to the Community Care Access Centre (CCAC) admission notes this behaviour was most likely to occur during scheduled breaks or when there were fewer staff on the unit and with residents who were in wheelchairs or broada chairs who were cognitively impaired.

Resident #064 was admitted to the home due to his/her responsive behaviour. At the time of the incident on an identified date, resident #064 had cognitive impairment.

Record review of resident #063's progress notes indicated on an identified date, at around 2130 hours resident #063 attempted to touch a co-resident but staff intervened and redirected the residents. A DOS monitoring every 30 minutes was initiated after the incident had occurred. The resident had been assessed by the occupational therapist (OT) who followed up with the team to assess the resident's behaviour and set behavioural goals.

Record review of resident #063's progress notes on an identified date, indicated that resident #063 attempted to touch resident #064 at around 1430 hours and RPN #171

intervened and redirected the residents and close monitoring continued. A review of resident #063's DOS monitoring on an identified date, indicated that resident had been awake most of the day shift, and there were no documentation of the attempted behaviour on the DOS nor on the daily resident/staff communication report.

Interviews with RNs #164, #172, and #192 revealed that there had been no assessment or reassessment of resident #063 after both incidents on two identified dates. The RNs indicated that no other interventions were implemented other than the 30 minutes DOS monitoring that was started on an identified date, and resident #063 could be seen from the nursing station .

Both residents were discharged from the home.

Interviews with RNs #164, #172 and #192 revealed that resident #063 was admitted to the home with an identified responsive behaviour of inappropriate touching of co-residents when there is less staff around. Resident #063 will target residents who are vulnerable or cognitively impaired, in wheelchairs or broada chairs that could not defend themselves. The RNs further revealed that no responsive behaviours had been indicated on resident #063's 24 hour admission plan of care. A review of resident #063's progress notes and interviews with staff revealed that the only interventions in place were DOS monitoring after the first incident had occurred.

Interviews with NM/ADON #126 revealed that the residents were not protected from abuse of inappropriate touching by resident #063. [s. 19. (1)]

(649)

5. Record review of CI of an identified date in 2016 revealed resident #033 reported that PCA #182 was abusive to him/her.

Interview with resident #033 revealed he/she shared a washroom with co-resident and on that particular day, he/she had overheard PCA #182 and his/her roommate speaking with raised voices. Resident #033 went to the washroom after PCA #182 and the co-resident exited, and observed that the washroom floor and toilet seat were wet, and dirty gloves were on the sink. The resident stated that this was unprofessional and went to report his/her concern to RN #135. PCA #182 approached resident #033, and questioned his/her actions. Resident #033 revealed PCA #182's questioning made him/her feel intimidated when the staff asked why he/she reported his/her concerns.

Interview with (RN) #135 revealed that on the day of the incident, resident #033 had approached him/her to go to his/her washroom to observe the environment, and RN #135 had observed that the floor was wet around the toilet, and observed the dirty gloves on the counter. RN #135 approached PCA #182 to inform the PCA that he/she should have cleaned the washroom as it was his/her assignment, and that the PCA had agreed.

The NM/Acting DON #126 revealed that resident #033 was not protected from abuse by the staff. [s. 19. (1)]

(646)

6. Record review of CI of an identified date in 2017 revealed resident #032 reported that a practical care aide (PCA) was abusive to him/her when he/she requested care and assistance on the night shift on this same date.

Record review of resident #032's written plan of care revealed that the resident required extensive physical assistance from one staff for transfers and walking.

Interview with resident #032 revealed that on January 2017, he/she requested PCA

#183 to assist him/her with identified care. PCA #183 responded to resident #032 in a rude manner and stated that the resident could do everything for his/herself.

Resident #032 requested PCA #183 to pass an item and PCA #183 asked the resident why he/she wanted the item, and the resident revealed that he/she wanted to go to the nursing station .The resident revealed that PCA #183 then shut the door to his/her room and offered him/her no assistance. The resident revealed that this made him/her very upset and was up all night because of it. Resident #032 informed the registered practical nurse (RPN) #186 that he/she did not want PCA #183 to provide his/her care again.

Interview with RPN #186 revealed that resident #032 came to him/her at the nursing station that night and reported the encounter between the resident and PCA #183. The RPN #186 further revealed that the resident was upset by the incident.

Interview with nurse manager/acting director of nursing (NM/Acting DON) #126 revealed that PCA #183's behaviour in telling the resident that he/she did not require extensive assistance and not helping the resident, was unacceptable. He/she revealed that resident #032 was not protected from abuse. [s. 19. (1)]

The severity of the non-compliance and the severity of the harm were actual as it relates to residents #032, #033, #021 and #024.The scope of the noncompliance was isolated. A review of the compliance history revealed that there was a Voluntary Plan of Corrective Action (VPC) issued in inspection #2016_168202_0020, dated November 2, 2016, and a compliance order issued in inspection 2016_413500_0011 on November 25, 2016. As a result of the severity, scope and the licensee's previous compliance history, a compliance order is warranted. [s. 19. (1)]

(646)

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

Sep 08, 2017(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 : 002

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

Pursuant to / Aux termes de :

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.

Order / Ordre :

Ensure all staff use safe transferring and positioning techniques when transferring and positioning residents who require use of a tilt wheelchair.

Grounds / Motifs :

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

Record review of CI of an identified date in 2016 revealed resident #038, had a fall and sustained an injury to an identified body part related to improper transferring and positioning techniques.

Record review of the resident #038's written plan of care on an identified date, revealed that he/she was at high risk for falls and required physical assistance of two or more staff to transfer the resident from bed to wheelchair. The resident used a mechanical lift for transfers. This written plan of care also revealed the resident required his/her wheelchair to be positioned to prevent the resident from falling.

Review of the home's investigation notes of the incident revealed that PCA #182 transferred resident #038 manually on his/her own, had not affixed the resident's foot rests on the wheelchair, had not positioned the resident's wheelchair, and left

resident #038 in his/her room unattended while the PCA went to the morning report.

Interviews with PCA #140, RPNs #141, #169, and RN #135 revealed that resident #038 was a two-person transfer and used a mechanical lift and the proper set-up of the resident's wheelchair included the footrests for the resident. PCAs #140, #168, and RPNs #141 and #169, who were working on the shift that day, further revealed that PCA #182 did not ask them to assist with transferring resident #038 that morning.

Interviews with RPN #141 and RN #135 revealed that resident #038's wheelchair was not positioned and the footrests were not attached to resident #038's wheelchair when they arrived in the resident's room on an identified date.

Interview with NM/ADON #126 revealed that PCA #182 left resident #038, who was at high risk for falls, unattended in his/her room. The NM/ADON #126 further revealed that PCA #182 did not transfer and position resident #038 as specified in the resident's written plan of care, and the resident fell out of her wheelchair and sustained the above mentioned injury.

The severity of the non-compliance and the severity of the harm were actual. The scope of the non-compliance was isolated. A review of the Compliance history revealed that there was a Voluntary Plan of Corrective Action (VPC) issued in inspection #2016_516650_0004, dated September 27, 2016. As a result of the severity, scope, and the licensee's previous compliance
(646)

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

Sep 08, 2017(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks.
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks.
3. The type and level of assistance required relating to activities of daily living.
4. Customary routines and comfort requirements.
5. Drugs and treatments required.
6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions.
7. Skin condition, including interventions.
8. Diet orders, including food texture, fluid consistencies and food restrictions.
O. Reg. 79/10, s. 24 (2).

Order / Ordre :

Upon receipt of this report the licensee shall prepare a plan to include but not limited to:

1.Train all registered staff how to develop a 24 hour plan of care, ensuring all pertinent information as outlined in O. Reg. 79/10, s. 24 (2) is included in the plan.

This plan is to be submitted via email to inspector natalie.molin@ontario.ca by
June 29, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that the care plan must identify any risks the resident may pose to others, including any potential behavioural triggers, and safety

measures to mitigate those risks.

Record review of two CIs on identified dates revealed that resident #023 had been identified as involved in three resident to resident altercations which resulted in injury to the co-residents.

Resident #023 was admitted to the home on an identified date, from another Long term care home.

Record review of the home's incident report revealed that on an identified date, resident #023 grabbed the walker of resident #024 causing an altercation between the two residents and as a result of this altercation resident #024 fell to the floor and suffered an injury.

Record review of resident #023's progress notes on an identified date, revealed that resident #023 was to be put on the Dementia Observation System (DOS) monitoring, and that staff were to monitor his/her whereabouts.

Record review of the home's incident reports revealed that on an identified date, resident #023 grabbed resident #021.This incident occurred in the middle of the night when resident #021 was sleeping in a chair in the common area and resident #023 approached him/her and grabbed him/her and this caused an altercation between the two residents. No injuries were identified as a result of this altercation.

Record review of the home's incident report revealed that on an identified date, at 1600 hours resident #023 tried to take an item from a co-resident and then punched the co-resident on an identified body part. No injuries were identified as a result of this altercation.

Record review of resident #023's progress notes on an identified date, revealed that he/she continued to wander around the unit and refused to settle and that he/she was put on one to one monitoring, the doctor was informed and this was to be endorsed to the day shift.

Record review of resident #023's chart revealed that the initial, 24 hour plan of care had not been developed for this resident.

Record review of resident #023's progress notes made no further mention of resident

#023 having one to one monitoring and could not identify that new interventions were implemented to minimize the risk of altercations and potentially harmful interactions between the residents.

Interview with the Acting Director of Nursing (ADON) #125 revealed that there was no care plan developed which identified any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks.

The severity of the non-compliance and the severity of the harm were actual. The scope of the non-compliance was isolated. A review of the compliance history revealed no previous non-compliance. As a result of the severity and scope a compliance order is warranted. [s. 24. (2) 2.]

(618)

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

Sep 08, 2017(A1)

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

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

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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
Toronto ON M5S 2B1
Télécopieur : 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 13 day of July 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : NATALIE MOLIN - (A1)

Service Area Office /
Bureau régional de services : Toronto