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 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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 17, 2019	2018_644507_0027	031473-18	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

STELLA NG (507)

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): November 29 and 30, 2018, December 3 and 4, 2018. In addition, off site record reviews were conducted on January 3, 4, 7 and 8, 2019.

The following complaint intake was inspected:
#031473-18 related to plan of care.

During the course of the inspection, the inspector(s) spoke with the Home Administrator, Acting Director of Care/Nursing (A-DOC), Nurse Manager (NM), Registered Nurse (RN), Home Physician (HP) and substitute decision-maker (SDM).

The inspector conducted observations of staff and resident interactions, provision of care, record review of resident and home records, staffing schedules and relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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 resident #001 was not neglected by staff.

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) on an identified date in regard to resident #001's treatment received in the home.

In an interview, resident #001's substitute decision-maker (SDM) stated that resident #001 was on a lot of medications while in the home for two identified months, which put the resident in an identified state. Resident #001's SDM requested the resident to be transferred to another health facility where the resident was treated prior. An identified medication (Medication A) was prescribed for resident #001 on an identified date for an identified health condition (HC-A). Five days later, resident #001's SDM was notified a bed was available at the requested health facility for the resident. Resident #001 was transferred there on the same day. Resident #001 was having HC-A when they arrived at the requested health facility, and was sent to the acute hospital two days later. Resident #001's SDM also stated that they were aware the resident was still on Medication A, but not aware of the condition that resident #001 was still having HC-A at the time of the transfer. Otherwise, resident #001's SDM would not agree to the transfer. Resident #001's SDM further stated that they believed due to the treatment resident #001 received at the home, the resident developed an identified health condition (HC-B) and then passed. Resident #001's SDM did not think the resident was getting the necessary care, or being fed properly.

Review of resident #001's health record indicated the resident was admitted to the home on an identified date, and was transferred to another health facility approximately three months later. Review of resident #001's progress notes, physician's orders and medication administration records (MAR) indicated that staff #103 spoke with the resident's SDM on an identified date and prescribed an identified medication (Medication B) for a specific health condition (HC-C), and to continue Medication C if needed.

Review of resident #001's progress notes and MARs for a period of three months indicated the resident developed HC-A on an identified date, was administered Medication C on the same day. Resident #001 was assessed by the doctor the next day and Medication A was prescribed for HC-A. Resident #001 continued to have HC-A despite taking Medications A, B and C for the next four days. On the fifth day, resident #001 was transferred to the requested health facility.

Review of resident #001's progress notes for a period of five days prior to the transfer indicated there were no further assessments and/ or investigations completed in regard to the resident's ongoing HC-A once Medication A was administered. Home physician

was not notified of the ongoing HC-A.

In an interview, staff #104 stated that staff should have contacted the home physician when the resident was on Medication A and was still having HC-A. Home needed to find out the cause of the HC-A. It was possible that the prescribed Medication A was not working, and the resident needed to be on another medication; or the resident had something else that caused the HC-A. Staff #104 further stated that staff should not have given resident #001 Medication B and C for HC-A for days without informing the doctor. [s. 19. (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 no resident is neglected by staff, to be implemented voluntarily.

Issued on this 24th day of January, 2019

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

Original report signed by the inspector.