Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

# Inspection Report under the Long-Term Care Homes Act, 2007

# 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**

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| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 8, 2019 | 2019_650565_0017 | 027770-18, 013431-19 | Critical Incident System |

## Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 365 Bloor Street East, 15th Floor TORONTO ON M4W 3L4

## 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

MATTHEW CHIU (565)

## 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 12, 16, 17, 19, 20, 23, 24, and 25, 2019.**

**During the course of the inspection, the following Critical Incident System (CIS) intake logs were inspected:**
**- 027770-18 related to alleged staff to resident abuse, and**
**- 013431-19 related to falls prevention.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Administrator (AA), Manager of Resident Services (MRS), Nurse Managers (NM), Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents, and Family Member.**

**The inspector conducted observations of resident to resident interactions, staff to resident interactions and 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:**
**Falls Prevention**
**Prevention of Abuse, Neglect and Retaliation**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised at any other time when care set out in the plan has not been effective.

Review of a CIS report revealed that resident #001 was found on the floor on an identified date. The resident was transferred to the hospital and diagnosed with a specified significant injury.

Review of resident #001's Resident Assessment Instrument – Minimum Data Set (RAI-MDS) assessment and the plan of care during the period of the above mentioned fall revealed the resident had both cognitive and physical impairments. The falls prevention plan of care stated the resident was at risk for falls and had the specified falls prevention interventions implemented for the resident. The interventions were revised during an identified period, and the falls prevention plan had a specified goal.

Review of resident #001's post fall assessments and progress notes revealed the resident had three identified falls and injuries after the above mentioned interventions was last revised.

Interviews with PSW #104 and RPN #105 indicated resident #001 was at risk for falls because of the specified conditions. PSW #104 did not recall any change in the resident's fall prevention interventions during the above falls. Further reviewing resident #001's falls prevention plan with RPN #105 indicated no changes was made to the falls prevention interventions after it was last revised. The RPN stated the plan may help but it was ineffective, otherwise there would not be a fall.

Interview with RN #113, who was the falls prevention program lead, indicated that resident #001 was at risk for fall. The falls prevention plan of care was last revised on the identified date after the resident's fall on that day. RN #113 further stated the plan had been helping to reduce the number of falls but not effective to prevent the resident from falling and meeting the goal specified in the plan. The resident continued to fall, and sustained the above-mentioned injuries. The falls prevention plan of care had not been revised during this period.

Interview with NM #114 indicated that if the fall prevention plan of care had not been effective, the registered staff on the unit, together with the multidisciplinary team, should

make sure they try new strategies in the care plan. NM #114 acknowledged that resident #001's fall prevention plan of care was not revised when the care set out in their plan had not been effective. [s. 6. (10) (c)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident is reassessed and the plan of care reviewed and revised at any other time when care set out in the plan has not been effective, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance**

**Specifically failed to comply with the following:**

**s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Review of a CIS report revealed that on an identified date and time, an identified complaint was received by staff about the care given to resident #003 by PSW #111. The CIS report was submitted approximately two days after, and the Ministry of Long Term Care (MLTC) after hours was not contacted about this incident.

Review of the home's policy titled "Zero Tolerance of Abuse and Neglect", policy number RC-0305-00, indicated that a RN/RPN should inform the NM/RN-in-Charge immediately once an allegation, suspicion or witnessed abuse and/or neglect has been made (this includes informing the on-call manager). Continuously monitor resident and report unusual behaviour/reaction to abuse and/or neglect to physician; document in progress

notes and update Care Plan. The policy further stated that the RN-in-Charge should notify the Ministry of Health and Long Term Care immediately that an alleged, suspected or witnessed incident of abuse or neglect has become known and an investigation is underway. Document name date and time of notification in progress notes.

Review of resident #003's progress notes and the home's records indicated the former RPN #116 documented on the progress notes the day after the specified complaint was reported to them. On that day, former RPN #116 spoke with NM #114, and then at night the RPN emailed NM #114 and carbon copied to NM #115 the specified complaint they recorded on the progress notes.

Interview with NM #114 indicated former RPN #116 called them in the evening and stated that there were concerns about the resident's care. NM #114 further stated the RPN did not mention the allegation of abuse. NN #114 told the RPN to document the concerns in the progress notes and email them what they documented. On the next day when NM #114 read the email, they became aware of the allegation of abuse. The incident was reported to MLTC the same day.

Interview with NM #115 indicated that the home's policy directs RN or RPN to report allegation and suspicion of abuse to their manager. If no manager is in the building, they should report it to the RN in charge. The RN in charge should report the incident to the MLTC and the on call manager. NM #115 stated that they did not receive report from the RN in charge about the incident, and they were not aware of the allegation of abuse until they read RPN #116's email. NM #115 confirmed that according to former RPN #116's documentation, when the allegation of abuse was reported to the RPN on the identified date, it had grounds to suspect an abuse happened and it should be reported immediately as per the home's policy, but they did not. [s. 20. (1)]

**Issued on this 17th day of October, 2019**

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

**Original report signed by the inspector.**