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_0016	016747-19, 016802-19	Complaint

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 Complaint 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 intakes related to falls prevention was inspected:
- Complaint intake log #016747-19, and
- Critical Incident System (CIS) intake log #016802-19.

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

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #002 collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

Review of a CIS report indicated that resident #002 fell on an identified date and time while walking with PSW #109. On the next day, a PSW reported the resident had the identified injuries and complaint, and an x-ray was ordered on two identified dates. Five days after the fall, the second x-ray result revealed an identified diagnosis. The resident was transferred to the hospital the same day and received the specified medical procedure the following day.

Review of resident #002's RAI-MDS assessment and the plan of care during the period of the above mentioned fall revealed that resident #002 had both cognitive and physical impairments.

Review of resident #002's progress notes revealed that the physician ordered an x-ray of the specified body area on an identified date. An x-ray was completed two days after for the wrong body area. On the following day, the physician was informed of the result and ordered another x-ray of the intended specified body area. An x-ray of the intended specified body area was completed on the same day. The progress notes further stated that the first requisition was completed in a specified manner and that the intended specified body area was not selected.

Review of the first x-ray requisition indicated it was completed in the specified manner and the intended specified body area was not selected for x-ray.

Interview with RN #108 indicated that they picked up the first x-ray order from the previous shift on the identified date. They made the first x-ray requisition and faxed it to the x-ray imaging.

Interview with RN #107 indicated that on the identified date, they called the x-ray imaging and found out they had the x-ray report for the resident's wrong specified body area. After confirmed by reviewing the report, the RN made another requisition for the x-ray, and informed the manager and the physician. When reviewing the first x-ray requisition with RN #107 during the interview, the RN stated it was unclear indicating the intended body area should have been x-rayed, and the wrong specified body area was taken the first time.

Interview with NM #114 indicated that the physician's x-ray order was part of resident #002's plan of care. They were aware the x-ray of the wrong body area was taken and it caused a delay in discovering the identified diagnosis. The NM acknowledged that staff failed to collaborate in the development and implementation of resident #002's plan of care related to the x-ray of the specified body area. [s. 6. (4) (b)]

2. The licensee has failed to ensure that the care set out in resident #002's plan of care was provided to the resident as specified in the plan.

Review of resident #002's plan of care stated that the resident was at risk for falls and had interventions put in place for their falls prevention. The plan further stated resident #002's plan of care related to mobility.

Interview with PSW #106 indicated that resident #002 used two types of mobility devices and required the specified assistance when using one of them.

Interview with PSW #109 indicated that on the identified date, they provided assistance for resident #002 when they were using the mobility device. The PSW stated the identified descriptions of the interaction and assistance that they gave the resident before and leading to the above-mentioned fall. The described assistance was not the same as it specified in the resident's plan of care.

Interviews with RNs #107, #113, and NM #114 indicated that resident #002 required the specified assistance for transferring and walking. RN #113 and NM #114 confirmed that during the above mentioned incident, when PSW #109 did not provide the specified assistance for walking resident #002, the care was not provided to the resident as specified in the plan. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
- the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other,
- the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

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.