Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
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5700, rue Yonge 5e étage
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Public Copy/Copie du rapport 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 22, 2020	2019_767643_0035	015455-19, 018295-19, 023778-19	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

ADAM DICKEY (643)

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): December 30, 31, 2019, January 2, 3, 7, 8 and 9, 2020.

The following Critical Incident System (CIS) intakes were inspected during this inspection:
Log #018295-19, CIS #M512-000018-19 - related to fall prevention and management; and
Log #023778-19, CIS #M512-000023-19 - related to responsive behaviours.

The following Compliance Order (CO) follow-up intake was inspected during this inspection:
Log #015455-19 - related to prevention of neglect and medication management.

During the course of the inspection, the inspector(s) spoke with the Acting Director of Nursing (ADON), Nurse Manager - Operations (NM), Registered Nurses (RN), Registered Practical Nurses (RPN) and Personal Support Workers (PSW).

During the course of the inspection, the inspector observed staff to resident interactions and the provision of care, reviewed resident health records, the home's internal investigation notes, training records, admission/ readmission medication reconciliation audit forms and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2019_780699_0017	643

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 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 used safe transferring techniques when assisting resident #016.

A Critical Incident System (CIS) report was submitted to the Director related to an incident which caused an injury to resident #016 that required transfer to hospital and resulted in a change in the resident's condition. According to the CIS report, on an identified date, resident #016 had been assisted to the toilet by PSW #110 when the resident was unable to stand and was assisted to the floor by the PSW. Approximately two hours and 15 minutes later, resident #016's family member visited and reported that the resident was experiencing pain. Resident #016 was transferred to hospital several hours later where they were diagnosed with a specified injury.

Review of resident #016's care plan showed that they were to be assisted with transferring and toileting by two staff members. The care plan showed that resident #016 was able to transfer with physical assistance with the help of two staff members when alert, and a mechanical lift was required for transfers with two staff assistance at all other times.

Review of the home's investigation notes showed that PSW #110 had toileted resident #016 and assisted with peri-care when the resident began to have difficulty standing. The investigation notes indicated that PSW #110 assisted resident #016 to the floor and the PSW called PSW #112 for assistance. PSWs #110, #111 and #112 assisted resident #016 up from the floor.

In an interview, PSW #110 corroborated the home's investigation notes in which they acknowledged assisting resident #016 with transferring and toileting on the above identified date, when the resident had a fall incident. PSW #110 indicated they were aware that resident #016's care plan instructed staff to assist the resident with two staff members with transferring and toileting. PSW #110 acknowledged that they had assisted resident #016 with transferring without the assistance of another staff member.

In an interview, ADON #101 indicated that it was the expectation of the home for staff to follow resident care plans and provide transferring assistance with the number of staff indicated by the care plan. ADON #101 acknowledged that resident #016 was not assisted with transferring by staff using safe transferring and positioning techniques. [s. 36.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place was complied with.

As required by the Regulation (O. Reg. 79/10, s. 48 (1). 1) the licensee was required to ensure that an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury was implemented in the home. As required by the Act [LTCHA 2007, c. 8, s. 8. (1) (b)] the licensee was required to ensure there was an organized program of personal support services for the home to meet the assessed needs of the residents. As required by the Regulation (O. Reg. 79/10, s. 30 (1). 1) written descriptions of the programs were required that included the goals and objectives and relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Review of the home's policy titled Falls Prevention and Management, policy number RC-0518-21, published September 1, 2019, showed that a fall was defined as any unintentional change in position where the resident ends up on the floor, ground or other lower level.

Review of the home's policy titled Personal Support Worker (PSW), policy number NU-0201-06, published January 1, 2019, showed the roles and responsibilities of the PSW staff included:
- Participating with other members of the care team by providing resident information; and
- Observing and reporting changes in resident's physical, mental, and emotional condition promptly to the registered staff.

Review of CIS report mentioned in WN #1 showed that resident #016 had been lowered to the floor on an identified date by PSW #110. The CIS report showed that PSW #110 and two additional PSW staff assisted resident #016 from the floor. The CIS report further showed that the incident was not reported to registered staff.

In an interview, PSW #110 indicated that they were assisting resident #016 with care when the resident began to have difficulty standing, and PSW #110 assisted in lowering resident #016 to the floor. PSW #110 indicated that they did not believe that this was considered a fall as the resident was assisted to the ground and there did not appear to be any injury or pain at the time. PSW #110 acknowledged that they had not reported the incident to registered staff, and that it was the protocol in the home for PSW staff to report any incidents of falls, or changes in resident weight bearing ability to the registered staff on duty.

In interviews, PSWs #111 and #112 indicated that they had assisted resident #016 along with PSW #110 to transfer the resident from the floor on the above identified date. Both PSW staff indicated that they had reminded PSW #110 to report to the registered staff that resident #016 had ended up on the floor. PSWs #111 and #112 indicated that it was the responsibility of PSW staff to report any fall incidents to registered staff in order for the resident to be assessed for injury.

In an interview, ADON #101 indicated that the definition of a fall in the home was any unintentional change in position which results in a resident ending up on the floor or other surface. The ADON indicated that an instance in which a resident began to fall but was assisted to the floor by staff would be considered a fall by the home and should be reported to registered staff for assessment. The ADON indicated that it was the responsibility of PSW staff to report any resident fall incidents registered staff for assessment immediately. The ADON indicated that the PSW staff failed to report the incident to registered staff as a fall on the above identified date, and as such a prompt

assessment of the resident post-fall was not completed. [s. 8. (1) (a),s. 8. (1) (b)]

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 policies under the program for personal support services required by the Act [LTCHA 2007, c. 8, s. 8. (1) (b)] are complied with; and
- the policies under the program for fall prevention and management required by the Regulation (O. Reg. 79/10, s. 48 (1). 1) are complied with, to be implemented voluntarily.

Issued on this 29th day of January, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ADAM DICKEY (643)
Inspection No. / No de l'inspection :	2019_767643_0035
Log No. / No de registre :	015455-19, 018295-19, 023778-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 22, 2020
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
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 :	Tim Burns

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

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 # / No d'ordre : 001

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

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 :

The licensee must be compliant with O. Reg. 79/10, s. 36.

Specifically, the licensee must:
1) Ensure that for resident #016 and all other residents who require two-person assistance with transferring; staff use safe transferring techniques to assist the resident.

2) Develop and implement an auditing system in the home to ensure staff are assisting
residents with transferring using safe techniques according to the resident care plan.

3) Maintain a written record of audits conducted of transferring techniques in the home. The written record must include the date and location of the audit, the resident's name, staff members audited, equipment utilized, the name of the person completing the audit and the outcome of the audit.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring techniques when assisting resident #016.

A Critical Incident System (CIS) report was submitted to the Director related to an incident which caused an injury to resident #016 that required transfer to hospital and resulted in a change in the resident's condition. According to the CIS report, on an identified date, resident #016 had been assisted to the toilet by PSW #110 when the resident was unable to stand and was assisted to the floor by the PSW. Approximately two hours and 15 minutes later, resident #016's

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The severity of this issue was determined to be a level 3 as there was actual harm to resident #016. The scope of this issue was a level 1 as it related to one of three residents reviewed. The home had a level 3 compliance history as they had previous noncompliance with O. Reg. 79/10, s. 36. in the last 36 months that included:
- a Written Notification (WN) and Compliance Order (CO) issued July 13, 2017, with a compliance order due date of September 8, 2017. (643)

Ontario

Ministry of Long-Term Care

Ministère 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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Apr 22, 2020

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 22nd day of January, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Adam Dickey

Service Area Office /
Bureau régional de services : Toronto Service Area Office