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

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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
Mar 13, 2020	2020_630589_0006	000756-20, 002719-20, 003330-20, 003391-20	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

JOANNE ZAHUR (589), 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): March 5, 6, 9, 10, & 11, and March 12 (off-site), 2020.

The following inspections were conducted:
-Log #000756-20 related to staff to resident abuse,
-Log #002719-20 related to oral care and weight loss, and
-Log #003330-20 and #003391-20/CIS #M512-000008-20 related to an injury of unknown cause.

During the course of the inspection, the inspector(s) spoke with the Administrator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitian (RD), Golden Care Mobile Dental Services dentist, residents, and Substitute Decision Makers (SDM).

During the course of the inspection, the inspector conducted observations of the home including resident home areas, resident and staff interactions, resident to resident interactions, the provision of resident care, reviewed clinical health records, internal investigation notes and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

The licensee has failed to ensure staff used safe transferring techniques when assisting resident #001.

A critical incident system (CIS) report was submitted to the Director related to resident #001. The CIS report indicated that resident #001 presented with an area of altered skin integrity which resulted in a transfer to hospital. The hospital assessment indicated a diagnosis of an injury to this area of altered skin integrity.

A review of resident #001's health record indicated they required two staff total assistance for transferring with an identified transferring aid.

A review of the long-term care home' s (LTCH) internal investigation notes indicated that staff #121 had provided care to resident #001 on the identified day of the injury and on the previous day as well. The notes further indicated that during an interview with staff #103, staff #121 admitted they had provided care on both days, using the identified transferring aid unassisted.

During a phone interview, staff #121 acknowledged that the LTCH's interview notes were accurate and that they had provided care to resident #001 unassisted on both of the above identified days and also on other occasions when they had been assigned to the care of this resident. Staff #121 stated they were always careful and that using the identified transferring aid alone is safe if you are careful. Staff #121 further stated they were aware that two staff are required when using this identified transferring aid as they had completed education on safe transferring techniques on an identified date in February 2020.

During conversations, staff #103 and staff #124 acknowledged that staff #121 had not used safe transferring techniques when assisting resident #001.

This non-compliance is additional evidence to compliance order #001 served on January 22, 2020, in report #2019_767643_0035 under O. Reg. 79/10, r. 36, with a compliance due date of April 22, 2020. [s. 36.]

Issued on this 16th day of March, 2020

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

Original report signed by the inspector.