Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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Original Public Report

Report Issue Date: December 20, 2022	
Inspection Number: 2022-1538-0001	
Inspection Type: Critical Incident System	
Licensee: City of Toronto	
Long Term Care Home and City: Cummer Lodge, North York	
Lead Inspector Joy Ieraci (665)	**Inspector Digital Signature**
Additional Inspector(s) Kehinde Sangill (741670) Ryan Randhawa (741073) Inspector Iana Mologuina (763) was also present during this inspection.	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
November 15-18, 21-25, 29, 30, December 1 and 2, 2022.

The following intake(s) were inspected:
- Intake #00001575-22 (CIS #M512-000004-22) related to improper/incompetent care;
- Intake #00007928-22 (CIS #M512-000017-22) related to an unexpected death;
- Intake #00007804-22 (CIS #M512-000015-22) related to an injury of unknown cause;
- Intake #00002937-22 (CIS #M512-000027-21) related to a missing resident;
- Intake #00006699-22 (CIS #M512-000001-22) related to falls;
- Intakes #00003227-22; (CIS #M512-000005-22); #00001618-22 (CIS #M512-000033-21); #00003386-22 (CIS #M512-000021-21); #00002666-22 (CIS #M512-000017-21); #00002892-22 (CIS #M512-000016-21); #00002930-22 (CIS #M512-000019-21); #00002934-22 (CIS #M512-000022-21); #00003607-22 (CIS #M512-000008-21); #00001788-22 (CIS #M512-000025-21); #00012373-22 (CIS #M512-000019-22) and #00005054-22 (CIS #M512-000037-21) were all related to abuse

The following intakes were completed in this inspection:
- Intake #00004895-22 (CIS #M512-000003-22) related to an injury of unknown cause and
- Intake #00003395-22 (CIS #M512-000011-22) related to a missing resident.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Prevention of Abuse and Neglect
Responsive Behaviours
Skin and Wound Prevention and Management
Falls Prevention and Management
Infection Prevention and Control
Residents' Rights and Choices

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care related to minimizing the risk of altercations amongst residents was provided to a resident.

The resident was at risk of altercations with other residents and required a specific intervention in their room to alert staff.

On two observations, the intervention was not observed in the resident's room.

A Registered Practical Nurse (RPN) stated that the resident was recently transferred from another

resident home area (RHA). The RPN was not aware that the resident required the intervention. The RPN indicated that the resident did not have any altercations with other residents in the RHA since their transfer.

The Nurse Manager (NM) acknowledged that the resident required the intervention.

The intervention was implemented on November 24, 2022.

Sources: Resident care observations; review of the resident's clinical records; and interviews with the RPN, NM and other staff. [741670]

Date Remedy Implemented: November 24, 2022

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 19 (1)

The licensee has failed to ensure that resident A was protected from physical abuse by resident B.

Rationale and Summary

The home submitted a critical incident system (CIS) report to the Ministry of Long Term Care (MLTC), regarding an incident of resident to resident abuse.

Section 2 (1) of Ontario Regulation 79/10 defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

The CIS report indicated that resident B was physically aggressive towards resident A. Resident A sustained an injury in the altercation.

Both residents had a history of physically responsive behaviours toward co-residents.

A few weeks prior to the incident, resident A had a physically responsive altercation with another resident. The home implemented an intervention to monitor resident A to avoid further altercations with co-residents.

At the time of the incident, a PSW did not ensure the intervention for resident A was in place, which lead to an altercation with resident B. During the altercation, resident B was physically aggressive, which caused an injury to resident A.

A Registered Nurse (RN) acknowledged that the PSW failed to protect resident A from abuse when they did not provide the resident's intervention. The home's investigation revealed that resident A's intervention to protect them from further altercations with co-residents was not in place at the time of this incident.

There was moderate impact to resident A as they sustained an injury during the incident. There was moderate risk because resident A did not have their intervention provided to prevent further altercations with co-residents.

Sources: Review of the home's investigation notes, CIS report, the residents' clinical records; and interviews with the RN and other staff. [741073]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021 s.6 (7)

1) The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary

The home submitted a CIS report to the MLTC, for an injury to a resident for which the resident was taken to hospital, and resulted in a significant change in their health status.

The resident was found unresponsive in a co-resident's room, with empty bottles of hazardous substances at the bedside. The resident was transferred to hospital and received treatment for an identified diagnosis.

The resident's plan of care indicated that staff were to ensure hazardous substances were inaccessible to the resident, including specified items that should not be at the entry and in their room with specific signage next to the items.

The items were observed at the entry and inside the resident's room without the signage present. The substitute decision-maker (SDM) told the inspector that the items were recently put in place.

A RN observed the specified items the following day and indicated that they were not to be present, and the plan of care was not followed.

The NM and Infection Prevention and Control (IPAC) Practitioner stated that the specified items were not to have been put in place, and there was a risk to the resident if they accessed the hazardous substances.

The home's failure to follow the plan of care, put the resident at risk of injury if they had accessed the hazardous substances.

Sources: Resident room observations; review of CIS report, the resident's care plan, home's investigation notes and hospital reports; and interviews with the RN, NM, IPAC Practitioner, SDM and other staff. [665]

2) The licensee has failed to ensure that the care set out in the plan of care was provided to a resident, related to falls interventions.

Rationale and Summary

The home submitted a CIS to the MLTC, related to the unexpected death of a resident.

The resident was at high risk for falls and the plan of care indicated that the resident had a specified behaviour. The care plan directed staff to ensure that an intervention was in place when the resident was in their wheelchair and in working condition.

A PSW indicated the intervention was in place prior to the incident. When they found the resident on the floor, the PSW confirmed that the intervention was not in working condition, as per the plan of care.

The resident may not have received timely intervention when the falls intervention was not in working condition at the time of the fall.

Sources: Review of CIS report and the resident's clinical records; and interviews with the PSW and other staff. [665]

WRITTEN NOTIFICATION: SAFE AND SECURE HOME

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 5

The licensee has failed to ensure that the home was a safe and secure environment for a resident.

Rationale and Summary

The home submitted a CIS to the MLTC, regarding a missing resident of over three hours.

The CIS report indicated that the resident was discovered missing and returned to the home a few hours later. An assessment upon their return, revealed the resident sustained an injury in the community.

The resident's plan of care indicated that they were an exit seeker and had a history of elopement. The care plan directed staff to check and document that a specified intervention was on the resident every shift.

The day prior to the incident, the resident returned to the home from a leave of absence (LOA). A RN assessed the resident but did not assess for the specified intervention. Two PSWs on two different shifts documented that the resident had the specified intervention but did not check that it was in place upon the resident's return from their LOA. The staff confirmed they did not ensure that the specified intervention was implemented when the resident returned from their LOA.

On the day of the incident, the resident was found in an identified area of the long-term care home (LTCH) and was brought back to their RHA by their assigned PSW. The PSW informed an RPN that the resident did not have the specified intervention in place.

A RN requested the specified intervention for the resident after the resident was already discovered missing.

The assigned PSW indicated they were aware that the specified intervention was not in place prior to

the resident leaving the RHA, and only informed the registered staff after they brought the resident back to the RHA.

The RN stated that there was a breakdown in communication with the RPN and the assigned PSW regarding the resident's intervention. Collaboration amongst the team did not occur and the intervention should have been put in place immediately to ensure the resident's safety.

The NM acknowledged that the incident was avoidable. The staff did not ensure that the resident had the specified intervention in place upon returning from their LOA and the registered staff should have obtained the intervention right away to ensure the resident's safety. They indicated that the staff did not implement any interventions to prevent the elopement after the resident was found in the LTCH, and that the RN and RPN did not collaborate with each other. The NM stated that the home did not ensure the home was a safe and secure environment for the resident.

There was actual risk of harm to the resident when the home did not ensure the specified intervention was implemented and did not implement interventions to prevent the resident from leaving the home.

Sources: Review of the resident's clinical records, CIS report, homes' investigation notes; and interviews with the NM, RNs, RPN, PSWs and other staff. [665]

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident had fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Rationale and Summary

The home submitted a CIS report to the MLTC, related to an injury of unknown cause to a resident.

The resident was found sitting on the floor by staff. A post-fall assessment was not completed.

After finding the resident, the resident had a change in their condition. The resident was transferred to the hospital the following day and was diagnosed with an injury.

The RPN indicated that they should have completed a post-fall assessment after the resident was found on the floor.

The NM acknowledged that a post-fall assessment was not completed.

There was risk that the resident would not receive timely treatment when the post-fall assessment was not completed.

Sources: Review of CIS report, home's investigation notes and the resident's clinical records; and interviews with RPN and NM. [741073]

WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 3 (1) 11. ii.

The licensee has failed to ensure that a resident's right to give or refuse consent to any treatment was fully respected.

Rationale and Summary

An RPN administered a treatment to a resident without their consent. The resident resisted the treatment and sustained an injury.

The resident stated that they told the RPN they did not want the treatment. The resident indicated that they felt helpless when they received the treatment.

NM acknowledged that the resident's right to refuse was not respected.

Failure to respect the resident right to refuse consent to treatment resulted in the resident feeling helpless and sustaining an injury.

Sources: Review of CIS report; home's investigation notes, the resident's clinical records; and interviews with the resident, NM, and other staff. [741670]

WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.

The licensee has failed to ensure that residents had their personal health information (PHI) within the meaning of the Personal Health Information Protection Act, 2004, kept confidential.

Rationale and Summary

A computer screen mounted on a medication cart displayed residents' names and PHI was left unattended in a common area in one RHA. There were residents and a family member in the vicinity at the time of the observation.

An RPN acknowledged that the screen should have been locked to protect the PHI of residents.

Failure to lock the computer screen when unattended could allow unauthorized access to the residents' PHI.

Sources: Observation in one RHA, and interviews with the RPN. [741670]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 11

The licensee has failed to ensure that the infection prevention and control (IPAC) Lead carried out their responsibilities related to the hand hygiene program.

Rationale and Summary

The IPAC Lead failed to ensure that that there was in place a hand hygiene program in accordance with the "IPAC Standard for Long Term Care Homes April 2022". Specifically, the IPAC Lead did not ensure that the hand hygiene program included 70-90% alcohol-based hand rub (ABHR) as required by Additional Requirement 10.1 under the IPAC Standard.

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Two bottles of ABHR with 62% alcohol content were observed on snack carts in the dining rooms in two RHAs.

A PSW indicated that the ABHR were used by residents prior to nourishment. The IPAC Practitioner acknowledged that the ABHR should be 70-90% according to their hand hygiene program.

The use of 62% ABHR reduced the effectiveness of the ABHR used in the home's hand hygiene program.

Sources: IPAC Observations; review of ABHR alcohol content label and IPAC Standard for LTCHs, dated April 2022; and interviews with the PSW and IPAC Practitioner. [741670]

WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The Licensee has failed ensure that a policy directive that applied to the LTCH, the Minister's Directive: COVID-19 response measures for LTCHs, was complied with.

In accordance with the Directive, licensees were required to ensure that enhanced environmental cleaning and disinfection for frequently touched surfaces as set out in the COVID 19 response measures document was followed.

The document required that the home follow Provincial Infectious Diseases Advisory Committee (PIDAC) best practices for environmental cleaning for prevention and control of infections in all health care settings. PIDAC indicated that expiration dates should be reviewed to ensure efficacy of disinfectants used.

Rationale and Summary

In one RHA, expired disinfectant wipes for cleaning high touch surface areas were observed. The wipes expired on November 19, 2021.

Heavy Duty Cleaner verified that the wipes were used to clean high touch areas.

The Manager of Building Services verified that expired disinfecting products should not have been used

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by staff.

The use of expired disinfecting wipes reduced the efficacy of environmental cleaning and the home's IPAC practices.

Sources: IPAC Observation; review of Diversey disinfectant wipe and expiration dates, Minister’s Directive: COVID-19 Response Measures for LTCHs, effective August 30, 2022, PIDAC–Infection Prevention and Control, April 2018; and interviews with Heavy Duty Cleaner #100 and Manager of Building Services #102. [741670]

WRITTEN NOTIFICATION: SKIN AND WOUND

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 50 (2) (b) (ii)

The licensee has failed to ensure that a resident who exhibited altered skin integrity, including skin tears, received immediate treatment to reduce or relieve pain.

Rationale and Summary

A resident sustained an injury during an interaction with an RPN.

An assessment conducted after the incident, indicated the resident complained of pain. The resident had an intervention for pain, which was not provided.

The resident stated that they complained of pain to the registered staff but did not receive the pain intervention.

A RN verified that the pain intervention was not provided when the resident complained of pain.

Not providing the pain intervention after pain was assessed may have led to a delay in managing the resident’s pain.

Sources: Review of CIS report, the resident’s clinical records; and interviews with the resident, RN, and other staff. [741670]