Ontario

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

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: December 21, 2023

Inspection Number: 2023-1538-0005

Inspection Type:
Critical Incident

Licensee: City of Toronto

Long Term Care Home and City: Cummer Lodge, North York

Lead Inspector	**Inspector Digital Signature**
Cindy Ma (000711)	Shuang Yu Ma Digitally signed by Shuang Yu Ma Date: 2023.12.28 13:54:39 -05'00'

Additional Inspector(s)
Ryan Randhawa (741073)

INSPECTION SUMMARY

The inspection occurred on the following date(s): November 30 and December 1, 4-7, 2023.

The following intake(s) were inspected:
- Intake: #00098679 - [Critical Incident (CI): M512-000035-23] was related to medication management
- Intake: #001000687- [CI: M512-000039-23] was related to alleged neglect
- Intake: #00094192 - [CI: M512-000027-23]; and Intake: #00100117 [CI: M512-000037-23] were related to infection prevention and control.
- Intake: #00100559 [CI: M512-000038-23] was related to fall with injury.

The following intake(s) were completed in this inspection: Intake: #00096600 -

[CI: M512-000032-23] and Intake: #00097146 [CI: M512-000034-23] were related to fall with injury.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
Integration of assessments, care
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

The licensee has failed to ensure the staff involved in the different aspects of care of a resident collaborated with each other in the assessment of the resident's foot care.

Rationale and Summary
A resident's family raised concerns to the Licensee about the condition of the

resident's toenails. On the same day, the resident was assessed by the Nurse Practitioner (NP). The NP's assessment indicated the resident's toenails needed additional interventions due to the state they were in.

Two PSWs confirmed that they noticed the condition of the resident's toenails prior to the specified day. One of the PSWs acknowledged that they should have reported it to the registered staff but failed to do so.

Nurse Manager (NM) confirmed that staff should have reported the condition of the resident's toenails to the registered staff. The NM acknowledged that there was lack of communication from the PSWs to the registered staff. The NM confirmed staff and others involved in the different aspects of care of the resident did not collaborate with each other.

The failure of staff and others to collaborate with each other placed the resident at risk of harm when resident's toenails care were not assessed in a timely manner.

Sources: Resident's clinical records; and interviews with PSWs and other staff. [000711]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
Integration of assessments, care
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,
(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.

The licensee has failed to ensure that staff and others involved in the different aspects of the care of a resident collaborated with each other in the implementation of a fall intervention.

Rationale and Summary

A resident fell and sustained an injury. The resident was at risk of falls and required interventions. During an observation, the resident was observed not utilizing the intervention.

A PSW verified that the interventions were not on the resident and acknowledged that they failed to encourage the resident to utilize the intervention because of a specified reason.

Three staff indicated that the PSW should have collaborated with the nurse to request for another pair of the same intervention.

Failure to collaborate in the implementation of the resident's interventions caused a risk of injury to the resident.

Sources: Observations of a resident; Resident's clinical records; Interviews with Nurse Manager and other staff.
[741073]

WRITTEN NOTIFICATION: Directives by Minister

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
Binding on licensees
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The Licensee failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, when masking requirements were not followed by three staff.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, and the COVID-19 guidance document for long-term care homes in Ontario, updated November 7, 2023; all staff, students, volunteers, and support workers wear a medical mask in all resident areas indoors.

Rationale and Summary

(i) A staff was observed at the nursing station on a resident home area without a face mask. The staff acknowledged being aware of the masking requirements but mentioned that it was removed during a break.

On another date, another staff was observed interacting with other staff within one meter distance without a face mask at the nursing station on a resident home area. The staff acknowledged they were required to wear a face mask but stated they forgot to do so.

The IPAC Lead confirmed that all staff must wear a face mask when inside the resident home areas at all times.

Staff's failure to don a face mask inside resident home areas increased the risk of infection transmission to residents, other staff and visitors.

Sources: Observations; interviews with the IPAC Lead and other staff; and Minister's Directive: COVID-19 response measure for long-term care homes, COVID-19 guidance document for long-term care homes in Ontario.
[000711]

(ii) A PSW was observed providing assistance to a resident within one meter distance, while wearing their face mask under their nose.

The PSW admitted that they were not wearing their face mask properly, by ensuring that their nose was not exposed.

The IPAC Lead stated that all staff must ensure that their face mask was properly fitted to cover the nose.

Staff's failure to appropriately don face masks increased the risk of infection transmission to residents, other staff and visitors.

Sources: Observation; and interviews with a PSW and IPAC Lead.
[000711]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program

s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that a PSW participated in the implementation of the home's infection prevention and control (IPAC) program related to personal protective equipment (PPE).

Rationale and Summary

A PSW was observed doffing their PPE in the following order: taking off the gown, then gloves followed by performing hand hygiene, after providing care to a resident who was on contact and droplet precautions.

The home's policy directed staff to remove protective equipment in the following order: gloves, gown, perform hand hygiene, protective eyewear, mask/N95 respirator, and hand hygiene. The IPAC Lead confirmed that the PSW did not doff their PPE in the appropriate order.

Staff not doffing their PPE in the appropriate order increased the risk of spreading infectious disease amongst residents, staff, and others.

Sources: Observation, home's personal protective equipment policy, and interview with IPAC Lead.
[000711]

COMPLIANCE ORDER CO #001 Plan of care

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. Educate all PSWS and registered staff on a specified resident home area on a resident's bathing requirements in their plan of care by the compliance due date of this order.
2. Maintain a record of the education, including the content, date, signatures of staff who attended and the staff member who provided the education.
3. Conduct audits of the level of bathing assistance provided to a resident for each shower / bath for a period of two weeks following the service of this order.
4. Maintain a record of the audits completed, including but not limited to, date of audit, person completing the audit, staff and resident audited, outcome and actions taken as a result of any deficiencies identified.

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

Rationale and Summary

A resident was assisted by a PSW with a shower. When the PSW was not present with the resident, they fell and sustained an injury.

The resident required a certain level of assistance for their showers, as indicated in the resident's plan of care.

The PSW confirmed that assistance was not provided as indicated in their plan of care. The PSW and Nurse Manager acknowledged that the resident's fall and injury could have been prevented if the resident was provided with the assistance as specified in their plan of care.

The Nurse Manager confirmed that the staff were expected to follow the interventions as specified in the resident's plan of care.

Failure to provide assistance for resident as specified in their plan of care, put the resident at risk for fall and injury resulting in harm to the resident.

Sources: Resident's clinical records; Interviews with PSW and other staff. [741073]

This order must be complied with by February 2, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Compliance Order (CO) #001 in Inspection #2023-1538-0002, issued April 14, 2023, under FLTCA, 2021, s. 6 (7).

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.