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: March 7, 2024
Inspection Number: 2024-1538-0001
Inspection Type: Critical Incident Follow up
Licensee: City of Toronto
Long Term Care Home and City: Cummer Lodge, North York

Lead Inspector	**Inspector Digital Signature**
Ramesh Purushothaman (741150)	Ramesh Purushothaman Digitally signed by Ramesh Purushothaman Date: 2024.03.21 09:07:54 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 12-16, 20 and 21, 2024.

The following intakes were inspected during this Critical Incident (CI) Inspection:

- Intake: #00102343/ CI #M512-000043-23, #00105842/ CI #M512-000001-24 and #00107043/ CI #M512-000002-24 were related to Infection Prevention and Control (IPAC).
- Intake: #00103417/ CI #M512-000044-23, #00104742/ CI #M512-000047-23 were related to fall prevention and management.

The following Compliance Order (CO) Follow up intakes were inspected:

- Intake: #00104767 - CO #001 was related to Plan of Care.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1538-0005 related to FLTCA, 2021, s. 6 (7) inspected by Ramesh Purushothaman (741150)

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

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

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)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer

necessary; or

The licensee has failed to ensure that resident's plan of care was revised when the care set out in the plan was no longer necessary.

Rationale and Summary
A resident's written plan of care indicated that they had falls prevention interventions in place when in bed.

Observation revealed that one of the falls prevention interventions was not implemented when the resident was in bed. Two Personal Support Workers (PSWs) acknowledged that the specific intervention was not in place at the time of the observation.

Review of the resident's progress notes, and their plan of care, indicated that one intervention was removed from their care plan. A Registered Nurse (RN) confirmed that they had revised the plan of care as the resident no longer needed the specified falls prevention intervention per the discussion with the interdisciplinary team.

There was no impact or risk to the resident when the specific falls prevention intervention was not implemented.

Sources: Resident's plan of care and progress notes, Critical Incident (CI) report, Interview with PSWs and RN.
[741150]

Date Remedy Implemented: February 15, 2024

WRITTEN NOTIFICATION: REQUIRED PROGRAMS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee has failed to ensure that registered staff completed pain assessments for the resident.

Rationale and Summary
A resident self-reported that they sustained a fall and was noted in pain seven times on four different dates. However, no pain assessments were performed using an appropriate pain assessment tool when the resident was in pain.

The home's policy titled: Pain Assessment and Management, #RC-0518-01, published February 1, 2020; stated to, "Complete the pain assessment for all residents, as follows: significant change in resident status and post fall, using the appropriate pain assessment tool".

A Registered Practical Nurse (RPN) indicated that they were required to complete a pain assessment using Abbey Pain scale, but was not completed when the resident was in pain on the above mentioned dates post fall. The Nurse Manager acknowledged that a pain assessment should have been completed by the

registered nurses using Abbey Pain scale when the resident was in pain.

Failure to complete pain assessments using Abbey Pain scale resulted in poor pain management.

Sources: Resident's clinical records, CI report, home's Pain Management Policy #RC-0518-01, published February 1, 2020, and interviews with the registered staff and Nurse Manager.
[741150]

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that pain medication was administered to the resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary
A resident self-reported that they sustained a fall and was noted in pain on certain days and times. The resident had orders for scheduled and as needed (PRN) pain medications.

The resident's medication record indicated that pain medication was not administered timely when the resident was complaining of pain.

An RPN, RN and the Nurse Manager all confirmed that when the resident was in pain on four different dates, the pain medication was not given as prescribed.

Failure of staff to administer pain medication to the resident as prescribed, resulted in poor pain management.

Sources: Review of resident's clinical records, CI report, Interviews with RPN, RN and the Nurse Manager.
[741150]