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

Original Public Report

Report Issue Date: June 28, 2024

Inspection Number: 2024-1538-0002

Inspection Type:
Proactive Compliance Inspection

Licensee: City of Toronto

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

Lead Inspector	**Inspector Digital Signature**
Susan Semeredy (501)	Susan L Semeredy Digitally signed by Susan L Semeredy Date: 2024.07.03 13:29:08 -04'00'

Additional Inspector(s)
Joy Ieraci (665)
Yannis Wong (000707)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 5, 6, 7, 10, 11, 12, 2024

The following intake(s) were inspected:

- Intake: #00117610 - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management

Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
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 (7)
Plan of care
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 licensee has failed to ensure that the care set out in a resident's plan of care was provided as specified in the plan.

Rationale and Summary

The resident was at nutritional risk. As an intervention, a Registered Dietitian (RD) ordered a certain amount to be provided at each meal. On two different days during a meal service, the resident received and consumed less than the full amount. Personal Support Workers (PSWs) at the table confirmed the amount the resident received was half of the amount ordered. The RD confirmed that the

resident's nutritional status would be at further risk if the resident was not receiving the full amount.

Failing to provide the resident with the full amount of their preference that was part of the care set out in their plan of care, put them at further nutritional risk.

Sources: A resident's clinical record, observations and interviews with an RD and other staff. [501]

WRITTEN NOTIFICATION: Air temperature

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The licensee has failed to ensure the home was maintained at a minimum temperature of 22 degrees Celsius.

Rationale and Summary

Record review of the home's air temperature logs between May 1 to June 9, 2024, identified documented air temperature below 22 degrees Celsius. Specifically, on May 1-3, 5-6, 10-11, 16-19, 23-31, and June 2-8, 2024, there were air temperature records that included readings between 18.7 to 21.9 degrees Celsius in resident rooms and common areas.

The home's policy, "Hot Weather Alert Response Policy" requires the home's temperatures to be maintained between 22-26 degrees Celsius.

A resident indicated the air temperatures in the home was always cold. The Manager of Building Services acknowledged that when the temperature fluctuates outdoors, the home was not been maintained at a minimum of 22 degrees Celsius.

Residents' comfort was at risk when the air temperature was not kept at a minimum temperature of 22 degrees Celsius.

Sources: The home's policy, "RC-0518-14: Hot Weather Alert Response", published January 11, 2023; air temperature logs; interviews with a resident and Manager, Building Services. [000707]

WRITTEN NOTIFICATION: Dining and snack service

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 7.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
7. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

The licensee failed to ensure that the home had a dining service that included, course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

Rationale and Summary

Two residents in the dining room were eating their entrée and their desserts were already on the table.

A Food Service Worker (FSW) stated a PSW asked for the entrée and dessert to be served at the same time for the two residents and was unsure if it was part of their plan of care. A PSW and an RN stated dessert should have been served once the residents had finished their entrée and neither residents' plan of care indicated menu items be served at the same time.

Failure to provide meals course by course increased the risk of the dessert not being at a palatable temperature by the time the residents finished eating their entrée.

Sources: Meal observation; interviews with an RN and other staff; a resident's care plan. [000707]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)
Dining and snack service
s. 79 (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The licensee has failed to ensure a resident who required assistance with eating, was only served a meal when someone was available to provide assistance.

Rationale and Summary

A resident who required total assistance with eating was served a meal without someone available to assist. A PSW stated they were aware the resident should not

have been served a meal until they were available to assist. A Nutrition Manager confirmed the resident should have had someone present to assist them immediately when they were served their meal.

Failure to ensure that the resident was served a meal when someone was available to provide assistance, increased the risk of the resident having a meal at an unpalatable temperature.

Sources: A resident's care plan, an observation and interviews with a Nutrition Manager and other staff. [501]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee has failed to ensure that symptoms indicating the presence of infection in a resident were monitored every shift.

Rationale and Summary

A resident was placed on Droplet/Contact Precautions. Their progress notes and assessments did not have documentation that the resident was monitored for their symptoms of infection during a shift for three days.

The Infection Prevention and Control (IPAC) Manager acknowledged that the resident was not monitored for symptoms of infection every shift as required.

Failure to monitor the resident's symptoms of infection every shift may have delayed the identification of any significant change in the resident's health status.

Sources: Review of a resident's clinical records and interviews with the IPAC Manager and other staff. [665]

WRITTEN NOTIFICATION: CQI Committee

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 10.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
10. One member of the home's Family Council, if any.

The licensee has failed to ensure the home's continuous quality improvement (CQI) committee included one member of the home's Family Council (FC).

Rationale and Summary

A FC member indicated they were not part of the CQI committee and were not aware of any member of the FC being a member. The CQI meeting minutes indicated there was a Family Council member as part of the committee. The FC Assistant and Administrator confirmed this family member who was part of the CQI committee, was not a member of the Family Council.

Failing to include a Family Council member in the home's CQI committee put residents at risk as a Family Council member may have insight into broader family concerns.

Sources: Minutes from the CQI meetings for March and April 2024 and interviews with a FC member and staff of the home. [501]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT INITIATIVE REPORT

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. iii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that the Continuous Quality Improvement (CQI) Initiative Report contained a written record of the dates when the results of the Resident and Family/Caregiver Experience Survey were communicated to families and members of the staff of the home.

Rationale and Summary

The CQI Initiative Report did not include the dates when the home communicated the Survey results to families and staff of the home, which was acknowledged by the Administrator.

There was no impact to residents, however the public did not have the required information in the home's CQI Initiative Report.

Sources: Review of the home's Quality Improvement Plan (QIP), dated March 28, 2024, and Narrative for Health Care Organizations in Ontario dated March 27, 2024; and an interview with the Administrator. [665]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT INITIATIVE REPORT

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. i.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
i. the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,

The licensee has failed to ensure that the CQI Initiative Report included the dates when actions were taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the Resident and Family/Caregiver Experience Survey.

Rationale and Summary

The CQI Initiative Report did not include the dates when actions were taken based

on the results of the Resident and Family/Caregiver Experience Survey, which was acknowledged by the Administrator.

There was no impact to residents, however the public did not have the required information in the home's CQI Initiative Report.

Sources: Review of the home's Quality Improvement Plan (QIP), dated March 28, 2024, and Narrative for Health Care Organizations in Ontario dated March 27, 2024; and an interview with the Administrator. [665]