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

Public Report

Report Issue Date: November 29, 2024

Inspection Number: 2024-1538-0005

Inspection Type:
Critical Incident

Licensee: City of Toronto

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

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: November 7, 8, 12 -14, 2024

The following intakes were inspected:

- Intake #00125659/ Critical Incident Report (CI) #M512-000037-24 related to fall.
- Intake #00126207/ CI #M512-000040-24 related to alleged staff to resident abuse.
- Intake #00128700/ CI #M512-000048-24 related to respiratory outbreak.
- Intake #00131165/ CI #M512-000050-24 related to unknown cause of injury to of a resident.

The following intakes were completed:

- Intake #00124331/ CI #M512-000033-24 and Intake #00126094/ CI #M512-000039-24 were related to falls.

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

Resident Care and Support Services
Infection Prevention and Control

Prevention of Abuse and Neglect
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: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard issued by the Director with respect to infection prevention and control (IPAC) has been complied with.
The home failed to ensure that that there was signage posted in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard), section 11.6. Specifically, the signage was not posted throughout the home.

Rational and Summary
Signage that lists signs and symptoms of infectious diseases for self-monitoring was not observed in place throughout the home.

A staff acknowledged that they did not ensure the signage was posted in all residents' areas.
Signage was posted throughout the home prior to inspector exiting the home.
Failure to post signage of screening measures in the home may increase the risk of infection transmission.
Source: Observations and interview with staff.
Date Remedy Implemented: November 12, 2024

WRITTEN NOTIFICATION: Nursing and Personal Support Services

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 11 (1) (b)
Nursing and personal support services
s. 11 (1) Every licensee of a long-term care home shall ensure that there is,
(b) an organized program of personal support services for the home to meet the assessed needs of the residents.

The licensee has failed to comply with nursing and personal support services program for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to have a nursing and personal support services program that must be complied with.

Specifically, a Personal Support Worker (PSW) did not comply with the home's "Nursing and Personal Care Records" policy.

Rationale and Summary
A resident had a fall that was not identified until the next shift. Staff discovered the resident's health condition had changed and transferred them to hospital. However, a PSW documented that the resident did not have any falls during their shift.

The home's Nursing and Personal Care Records policy indicated that staff should document care and services delivered each shift which should be based upon evidence of resident assessments and reflected nursing and personal care delivered.

The resident indicated that no staff had checked on them in their room. A registered nurse on the next shift was not made aware of the resident's fall. The assigned PSW confirmed that they did not check on the resident in their room or provide any care during their shift. They confirmed their documentation in POC did not accurately reflect the care provided to the resident.

Failure to follow home's "Nursing and Personal Care Records" policy caused a potential delay in identifying resident's fall and complete required assessments.

Sources: Resident's clinical records, home's policy, interviews with resident and staff.

WRITTEN NOTIFICATION: Responsive Behaviours Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours. A Personal Support Worker (PSW) did not implement the specific

strategy in response to a resident's behaviour.

Rationale and Summary
The plan of care identified a developed strategy in response to the resident's behaviour. A PSW did not implement the strategy and the resident's behaviour escalated until a Registered Practical Nurse (RPN) intervened.

The PSW stated that they did not implement the strategy in response to the resident's behaviour.

The failure to implement the developed strategy in response to the resident's behaviors led to escalation of resident's behaviour.

Source: Home's investigation records, resident's clinical records, and interviews with staff.

COMPLIANCE ORDER CO #001 Duty to protect

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. Provide education to two PSWs on the home's Fall Prevention and Management policy. Specifically, educate the staff on the required actions that should be taken post falls as it pertains to their role.
2. Conduct two random audits weekly, on a minimum of two residents, who had a fall incident to ensure all the required steps were taken post fall. These audits must

be conducted for a minimum of four weeks upon service of this order.
3. Maintain a written record of audits conducted, including but not be limited to: date of audit, resident name, staff name(s), all the actions taken post falls and any corrective action taken in response to the audit.
4.Keep a written record of the education provided to staff in step one of this order and ensure the following is included: the person providing the education, date of education provided, and the education content provided.

Grounds
The licensee failed to protect a resident from neglect when a fall incident was not reported to the registered nursing staff.

Section 7 of Ontario Regulation 246/22 defines "Neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary
A CI report was submitted to the Director, related to a resident's unknown cause of injury. The resident was discovered in severe pain, which resulted in transfer to hospital and being diagnosed with an injury. No records in the resident's clinical documents and the home's investigation notes identified the cause of injury.

A PSW confirmed that the resident had a fall on the previous shift. Two PSWs discovered the resident's fall prior to their shift exchange and they transferred the resident without using the appropriate equipment. They did not report the fall to the registered staff working that shift, nor the next shift. One of the two PSWs approached a registered staff later in the shift to report that the resident was experiencing pain, however, they did not report that the resident had a fall.

The home's Fall Prevention and Management policy indicated that registered

nursing staff should be informed of any fall incident, so that they could complete the required assessments and notify the physician or nurse practitioner immediately if a significant change is noted after the fall.

A Registered Nurse (RN) and a Registered Practical Nurse (RPN) who worked the shift that the resident fell indicated that they were not aware that the resident had a fall, otherwise they would have assessed the resident immediately. They also indicated that if the PSW staff informed them that the resident's pain was due to a fall, they would have monitored the resident more frequently. Furthermore, they indicated they would have contacted the physician and the resident's substitute Decision maker (SDM) soon after the PSW reported that the resident was experiencing pain.

When two PSWs failed to report the resident's fall immediately, transferred the resident manually without a registered staff's assessment, and failed to tell registered staff the possible cause of the resident's pain, delayed staff in providing the appropriate treatment and interventions placing the resident at increased risk of harm.

Sources: CI report, home's policy, resident's clinical record, interview with staff.

This order must be complied with by January 15, 2025

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.