Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 11, 12, 13, 14, 15, 2012	2012_078202_0016	Critical Incident

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6

Long-Term Care Home/Foyer de soins de longue durée

CUMMER LODGE
205 CUMMER AVENUE, NORTH YORK, ON, M2M-2E8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

VALERIE JOHNSTON (202)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Assistant Administrator, Nurse Manager, Registered Nurses, Personal Care Aides, Resident

During the course of the inspection, the inspector(s) observed the provision of care to residents, observed the Broda CS 385 commode shower chair, reviewed clinical health records, reviewed the home policy Minimal Lift and Resident Handling Policy and Broda CS 385 Commode Shower Chair Operating Manual

The following Inspection Protocols were used during this inspection:

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices and techniques when assisting resident A. [s.36.]

On May 21, 2012 at 11:00 hours resident A sustained a deep 10 cm long skin laceration on the right inner posterior thigh requiring 11 sutures during a transfer from Broda CS 385 commode shower chair to the resident's bed.

Resident A's care plan identifies this resident as having chronic lymph edema with multiple large loose skin folds to both upper and lower legs. Resident A is to be transferred using a mechanical Hoyer lift with two staff present and Broda CS 385 commode shower chair for all showers.

On May 21, 2012 at 11:00 hours, resident A received a shower in the Broda CS 385 commode shower chair. Upon completion of the shower, resident A was transferred back to the bed from the Broda CS 385 commode shower chair using a Hoyer mechanical lift with the assistance of a Registered Practical Nurse (RPN) and Personal Care Aide (PCA).

The (RPN) and (PCA) revealed in an interview that resident A began to scream in pain while being lifted out of the Broda CS 385 commode shower chair with the mechanical lift on May 21, 2012 at 11:00 hours. The (RPN) lowered resident A back into the Broda CS 385 commode shower chair and then the (PCA) assessed resident A.

The (PCA) noticed that resident A was bleeding from underneath the Broda CS 385 commode shower chair and that a large skin fold was trapped between the frame of the chair and wire basket used to hold a receptacle. The (PCA) released the skin fold by pushing the skin upwards from underneath the Broda CS 385 commode shower chair and resident A was then transferred back to bed.

Resident A was immediately transferred to hospital for further assessment of injury sustained during the transfer. Resident A returned to the home on May 21, 2012 at 19:00 with 11 sutures on right inner posterior thigh.

The Broda Model CS 385 Commode Shower Chair operating manual states in section 2.5.5 (7), titled Re-Positioning of Resident-"Danger of Clamping" that residents' and caregivers' body are to be observed and to be clear of all pinch points before operating the chair's functions. Failure to follow these safety measures can put the residents' or caregivers' limbs at risk of injury.

Staff interview confirmed that resident A was not repositioned or her body observed for pinching prior to the transfer on May 21, 2012 at 11:00 hours. [s.36.]

Staff interview revealed that the Broda CS 385 commode shower chair was never used for resident A as a commode chair. Staff identified to inspector that the receptacle had been removed from the Broda CS 385 commode shower chair for a long period of time leaving the removable wire basket exposed.

An order was previously issued on March 06, 2012 under inspection #2012_078202_001 ordering the licensee to develop and implement a plan to ensure staff use safe transferring and positioning devices or techniques when assisting residents.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following subsections:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that equipment is maintained in a safe condition and in a good state of repair. [s.15.(2)(c)]

Resident A's plan of care identifies this resident as having lymph edema and multiple loose skin folds on upper and lower thigh requiring the use of a Broda CS 385 commode shower chair for showering.

On May 21, 2012 at 11:00 during a transfer from the Broda CS commode shower chair resident A sustained a deep 10cm long skin laceration to the right inner posterior thigh requiring 11 sutures. Resident A's right inner posterior thigh skin fold became trapped between the wire basket and the chair frame underneath the Broda CS 385 commode shower chair seat.

Staff interview revealed that the Broda CS 385 commode shower chair used by resident A had only been used for showers and not as a commode chair.

Staff interview indicated that the receptacle for the Broda CS 385 commode shower chair had been removed by staff as it interfered with showering. The removable wire basket which houses the receptacle beneath the Broda CS commode shower chair was not removed and remained on the chair.

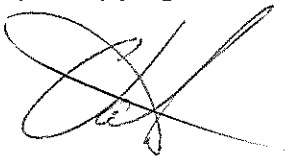
The Broda CS 385 commode shower chair had not been maintained in a safe condition prior to resident use.[s.15.(2)(c)].

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all equipment is maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

Issued on this 18th day of June, 2012

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs



Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	VALERIE JOHNSTON (202)
Inspection No. / No de l'inspection :	2012_078202_0016
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Jun 11, 12, 13, 14, 15, 2012
Licensee / Titulaire de permis :	TORONTO LONG-TERM CARE HOMES AND SERVICES 55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6
LTC Home / Foyer de SLD :	CUMMER LODGE 205 CUMMER AVENUE, NORTH YORK, ON, M2M-2E8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LEAH WALTERS

To TORONTO LONG-TERM CARE HOMES AND SERVICES, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that staff use safe transferring and positioning devices and techniques when assisting residents. Please submit plan to valerie.johnston@ontario.ca by June 29, 2012.

Grounds / Motifs :

1. The licensee failed to ensure that staff used safe transferring and positioning devices and techniques when assisting resident A. [s.36.]

On May 21, 2012 at 11:00 hours resident A sustained a deep 10 cm long skin laceration on right inner posterior thigh requiring 11 sutures during a transfer from Broda CS 385 commode shower chair to her bed.

Resident A's care plan identifies this resident as having chronic lymph edema with multiple large loose skin folds to both upper and lower legs. Resident A is to be transferred using a mechanical Hoyer lift with two staff present and Broda CS 385 commode shower chair for all showers.

On May 21, 2012 at 11:00 hours, resident A received a shower in the Broda CS 385 commode shower chair. Upon completion of the shower, resident A was transferred back to bed from the Broda CS 385 commode shower chair using a Hoyer mechanical lift with the assistance of a Registered Practical Nurse (RPN) and Personal Care Aide (PCA).

The (RPN) and and (PCA) revealed in an interview that resident A began to scream in pain while being lifted out of the Broda CS 385 commode shower chair with the mechanical lift on May 21, 2012 at 11:00 hours. The (RPN) lowered resident A back into the Broda CS 385 commode shower chair and then the (PCA) assessed resident A.

The (PCA) noticed that resident A was bleeding from underneath the Broda CS 385 commode shower chair and that a large skin fold was trapped between the frame of the chair and wire basket used to hold a receptacle. The (PCA) released the skin fold by pushing the skin upwards from underneath the Broda CS 385 commode shower chair and resident A was then transferred back to bed.

Resident A was immediately transferred to hospital for further assessment of injury sustained during the transfer. Resident A returned to the home on May 21, 2012 at 19:00 with 11 sutures on right inner posterior thigh.

The Broda Model CS 385 Commode Shower Chair operating manual states in section 2.5.5 (7), titled Re-Positioning of Resident-"Danger of Clamping" that residents' and caregivers' body are to be observed and to be clear of all pinch points before operating the chair's functions. Failure to follow these safety measures can put the residents' or caregivers' limbs at risk of injury.

Staff interview confirmed that resident A was not repositioned or her body observed for pinching prior to the transfer on May 21, 2012 at 11:00 hours.

Staff interview revealed that the Broda CS 385 commode shower chair was never used for resident A as a commode chair. Staff identified to inspector that the receptacle had been removed from the Broda CS 385 commode shower chair for a long period of time leaving the removable wire basket exposed.

An order was previously issued on March 06, 2012 under inspection #2012_078202_001 ordering the licensee to develop and implement a plan to ensure staff use safe transferring and positioning devices or techniques when assisting residents. (202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 06, 2012

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 15th day of June, 2012

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Valerie Johnston

Service Area Office / Bureau régional de services : Toronto Service Area Office