Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 7, 2013	2013_168202_0030	T-57-13	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): June 04, 05, 06, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Nurse Managers, Registered Nursing Staff, Personal Care Aides

During the course of the inspection, the inspector(s) observed the provision of care to residents, reviewed clinical records

The following Inspection Protocols were used during this inspection:
Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s.6. (7)]

Resident #001's plan of care identifies this resident as resistive to care and may become physically and verbally aggressive during care. The written plan of care for resident #001 indicates that a consistent care giver is to be provided as a strategy to prevent physically and verbal aggression during care. Staff interviews revealed that on an identified date, an identified Personal Care Aide(PCA) was assigned to provide resident #001's care. The (PCA) indicated in an interview that he/she normally works on another resident home area and had never provided care to resident #001 before. On an identified date, the (PCA) attempted to provide personal care to resident #001, who then became physically and verbally aggressive, and was observed to be lashing his/arms out while in bed, sustaining injuries. An interview with the Nurse Manager revealed that resident #001 is to be provided care by a consistent care giver and confirmed that on this particular date the identified Personal Care Aide assigned to resident #001 had not provided care to him/her before. [s. 6. (7)]

2. The licensee failed to ensure that provision of care set out in the plan of care are documented. [s.6.(9)1]

On an identified date, an identified Personal Care Aide (PCA) reported to an identified Registered Nurse (RN) that resident #001 sustained a skin tear during AM care when resident #001 became physically aggressive and lashed his/her arms out while in bed. An interview with the identified (RN)revealed that resident #001 was assessed for injuries and provided treatment to resident #001. The (RN) confirmed in an interview that the assessment and interventions provided to resident #001 were documented as a late entry in the progress notes on the following day. A review of the progress notes for resident #001, revealed that the provision of care related to one of the two treated injuries had been documented. [s. 6. (9) 1.]

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 the care set out in the plan of care is provided to the resident as specified in the plan and that the provision of care provided is documented, to be implemented voluntarily.

Issued on this 7th day of June, 2013

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