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
Sep 10, 2013	2013_157210_0020	T-323-13, T-379-13	Critical Incident System

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

SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 06, 07, 08, 09, 2013

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Nurses (RN), Physiotherapist (PT), RAI MDS Coordinator, Resident

During the course of the inspection, the inspector(s) reviewed the health records for residents #1, 2 and 3. Reviewed the homes falls prevention and responsive behavior program. Conducted a walk through of the 4th North and Special Care Unit.

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

Personal Support Services

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 O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

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1. The licensee failed to ensure that the home is equipped with a resident-staff communication response system that can be easily seen, accessed, and used by residents, staff and visitors at all times.
Observation of two resident rooms on 4th floor, on August 06, 2013 and interview with a PSW confirmed that cords were missing from the call bell\communication system located on the wall, beside resident beds and residents were unable to call for assistance.
Review of the written care plan indicates Resident#1 who resides in one of the identified rooms is at high risk for falls, she/he is incontinent of bladder and bowels, staff to observe resident hourly for safety and need for assistance, call bell to be within easy reach and staff to remind resident to use it. [s. 17. (1) (a)]

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 home is equipped with a resident-staff communication response system that can be easily seen, accessed, and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not

been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for Resident #1 sets out clear directions to staff and others who provide direct care to the resident.
The plan of care in relation to visual function indicates Resident #1 has impaired vision. The goal is to be safe while walking, and the strategy is to arrange for eye exam and provide lighting at night. The plan of care does not indicate that Resident #1 wears eye glasses. Observation of resident and interview with an identified PSW confirmed that Resident #1 uses eye glasses that need to be applied every morning. [s. 6. (1) (c)]

2. The plan of care in relation to mode of locomotion indicates Resident #1 does not use aids. Observation and interview with a PSW confirmed Resident #1 uses a wheelchair as a main mode of locomotion.
The plan of care in relation to transferring indicates Resident #1 requires limited assistance by one staff, one staff to cue resident to sit, support back and assist to swing feet to edge of bed, assist to stand, staff walk with resident for a few steps to steady resident and also two person assist for transfer. Interview with a PSW confirmed Resident #1 requires extensive assistance by two people for transferring [s. 6. (1) (c)]

3. The plan of care in relation to risk for falls indicates Resident #1 is at high risk for falls. Strategies to prevent falls are: staff to provide verbal cues when transferring, minimize environmental barriers, ensure proper lighting, keep adjustable bed in low position for safe transfers, observe resident hourly for safety and need for assistance, place call bell within easy reach and remind resident to use it.Observation of Resident #1's room revealed a floor mat that was rolled up besides the bed. The interview with PSWs and PT confirmed that the floor mat started to be used after the resident came back from hospital.The written plan of care does not set clear direction to staff to use the floor mat. [s. 6. (1) (c)]

4. The license failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.
The plan of care for Resident #2 indicates resident wanders\paces in the hallway or in and out of other resident rooms. Staff strategies in the behaviour tip sheet indicate if resident wandered into other resident's room, staff to approach gently and use gentle physical/verbal cueing to redirect resident out of the room. Interview with a PSW revealed that when Resident #2 wanders into other resident' rooms when he/she

needs assistance with toileting and he/she is calmer after his/her need are satisfied. This strategy was not shared with other team members and they were not aware of it. [s. 6. (4) (a)]

5. Review of the quarterly assessment from February and May 2013 for Resident #1 reveals that the wheelchair is the primary mode of locomotion. Interview with PSW, RN and PT confirmed that Resident #1 was walking until June 15, 2013 when she/he fell and sustained fracture. He started using the wheelchair as a main mode of locomotion after he returned from hospital. [s. 6. (4) (a)]

6. The licensee failed to ensure that the care set out in the plan of care is provided to Resident #1 as specified in the plan.
The plan of care in relation to assistance with urinary continence of Resident #1 indicates staff to prompt resident to toilet before breakfast, lunch, supper and bedtime. Review of the flow sheets and interview with a PSW confirmed that Resident #1 is prompted to toilet after breakfast and lunch. Night staff changes the brief in the morning before 07:00. [s. 6. (7)]

7. The licensee failed to ensure that staff and others who provide direct care to the resident are kept aware of the contents of the plan of care and have convenient and immediate access to it.
Review of the written plan of care and interview with PSW and RN confirmed that staff was not aware of the presence of behavioral tip sheet for Resident #2 and Resident #3 that were presented by the Nurse Manager to the inspector on August 09, 2013. [s. 6. (8)]

8. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised when resident's care needs change.
Review of the plan of care in relation to assistance with activity of daily living (ADL) updated on August 06, 2013 indicates Resident #1 does not use any aids for locomotion and he/she requires limited assistance, non-bearing assistance by one staff for walking in the room. Interview with PSWs confirmed Resident #1 requires extensive assistance by two staff since the resident returned from hospital. [s. 6. (10) (b)]

9. The licensee failed to ensure that Resident #1 was reassessed and the plan of care was reviewed and revised because the care set out in the plan has not been effective

and different approaches have been considered in the revision of the plan of care.
The review of incident reports revealed that Resident #1 had multiple falls in the last 4 months. During one of the falls, 2013 Resident #1 sustained a fracture. He/she was sent to the hospital for surgery and when the resident returned to the home, he/she fell again.
Review of the post fall assessment huddles revealed that different approaches have not been considered in the revision of the plan of care. [s. 6. (11) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's policies EM-0604-05 "Warning signs of a potentially violent person" from January 04, 2010, reviewed on January 04, 2013 and EM-0604-03 "Code white response-violent behaviour of a resident" from January 04, 2010 is complied with for Resident #3.

Review of the first policy indicates as purpose to assist in identifying, avoiding, mitigating, managing and\or defusing potentially violent incidents and threats.

Review of the second policy indicates as purpose to prevent injury to resident demonstrating violent behavior, other residents and staff. The policy states all staff to use caution if someone exhibits one or more of the following characteristics: history of violence, threatening behaviour, intimidating behavior, marked changes in mood or behavior, negative personality characteristics and also staff to report observations about potentially violent person to management.

Review of the progress notes confirms that on an identified date, Resident #3 came out of her/his room screaming, followed housekeeping staff, yelled at staff while doing care, refused redirection, and tried to turn over the linen cart. Review of the behavioral flow sheet reveals that at one hour later Resident #3 was still presenting with the same behavior. A Critical Incident Report indicates that staff heard screaming and they found Resident #3 and #2 on the floor. Resident #2's room is located on the other side of the unit, and he/she came over to Resident #3's room. Interview with a PSW reveals that when staff found both residents they already presented multiple cuts and blood on their faces, hair and hands. Staff did not defuse potentially violent incident and threats and did not prevent injury to the residents. [s. 8. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between Resident #2 and Resident #3 including implementing interventions.
Review of the plan of care of Resident #2 indicates resident is physically abusive, scratches and strikes out at staff, speaks loudly, wanders\paces in the hallway or in and out of other resident's rooms, refuses to stay in bed at night. Strategies identified to deal with this are: staff to approach in a gentle way using gentle physical\verbal cueing to redirect her/him out of the room and resident to be removed from the situation in case of altercation with another resident.

Review of the plan of care of Resident #3 indicates resident is verbally and physically abusive. Identified strategies how to deal with verbally and physically abusive behavior of Resident #3 are: staff to provide emotional support to resident as needed, allow space, have small talk in a friendly manner, use a supportive verbal and nonverbal attitude during conversations, acknowledge resident's concern and try to divert resident's attention to a more positive topic.

Review of clinical notes and behavioral observation flow sheet reveal that on an identified date Resident #3 was agitated and refused redirection by staff.
A Critical Incident Report reveals that there was an altercation between Resident #2 and Resident #3 in front of Resident #3' room that resulted in multiple face scratches\cuts for Resident #3 and multiple hands scratches for Resident #2.
Review of health records for Resident #2 and #3 and interview with PSWs and RN confirmed that interventions were not implemented for the harmful interaction between Resident #2 and #3. [s. 54. (b)]

Issued on this 10th day of September, 2013

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