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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 2, 2015	2015_440210_0013	029702-15	Resident Quality Inspection

Licensee/Titulaire de permis

City of Toronto
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), SARAH KENNEDY (605), TIINA TRALMAN (162)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 30, November 2, 3, 4, 5, 6, 9, 10, 12, 13, 16, 17, 2015.

During the resident quality inspection (RQI) a complaint #015757-15 was inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Administrator, Director of Nursing (DON), Nurse Managers (NM), Nutrition Manager, Registered Nurses (RN), Registered Practical Nurse (RPN), Personal Care Aide (PCA), Dietary Aide, Housekeeping staff, Maintenance staff, Manager/Supervisor Building Services, Social Worker, residents and family members, Family Council representatives, Residents' Council president.

During the RQI, the inspectors conducted an initial tour of the home, dining observation, reviewed resident health records, policies and procedures, staff education record, observed medication administration, staff to resident interactions and care.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

7 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and are locked when they are not being supervised by staff.

On October 30, 2015, inspector #210 observed that the door to the lift storage room S253 was unlocked. A sign was posted on the door indicating that the door lock was broken. On November 10, 2015, inspector #162 and the Manager/Supervisor Building Services observed the door to be unlocked.

On November 16, 2015, inspector #162 observed the door to the lift storage room S253 was unlocked. The RN #111 and the NM #128 were notified. Neither of them was aware that the door was unlocked. The NM #128 indicated that the door should be closed and locked when not in use. [s. 9. (1) 2.]

2. On October 30, 2015, inspector #210 observed the door to room N278 was unlocked and there was a posted sign on the door indicating "Maintenance only". No staff or residents were in the vicinity. An interview with RPN #147 indicated that the room is kept unlocked so that PCAs can access personal care supplies for residents.

On November 10, 2015, inspector #162 and the Manager/Supervisor Building Services observed the above mentioned door was unlocked. No staff or residents were in the vicinity. RPN #112 and RN #123 were notified.

An interview with the Manager/Supervisor Building Services confirmed that all doors leading to non-residential areas equipped with locks to restrict unsupervised access to those areas by residents, must be locked when they are not being supervised by staff. [s. 9. (1) 2.]

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 doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and are locked when they are not being supervised by staff, to be implemented voluntarily.

WN #2: 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 :

1. The licensee of a long-term care home has failed to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents.

On October 30, 2015, and November 10, 2015, inspectors #162 and #210 observed that the following common resident home areas were not equipped with a resident-staff communication and response system:

- Laundry room C413
- Laundry room C313
- Laundry room C213
- Day room S253
- Main floor where families, private caregivers, staff and residents have access to the cafeteria, front lobby by the café, west sitting area by reception, chapel room C111, games room N107, and auditorium room N132.

An interview with the Manager/Supervisor Building Services confirmed that residents, staff and visitors have access to the above mentioned areas and there is no resident-staff communication and response system available in these areas. [[s. 17. (1) (e)]

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 home is equipped with a resident-staff communication and response system that is available in every area accessible by residents, to be implemented voluntarily.

WN #3: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

A review of resident #003's written plan of care on November 12, 2015, indicated: the resident is on a scheduled toileting plan, staff prompt the resident to toilet, the resident wears a continent product during the day and night, and at night, he/she uses the toilet.

An interview with day PCA #144 revealed that the resident is assisted with toileting two times during day shift. An interview with evening PCA #142 revealed that the resident is assisted with toileting four times during the evening shift at specified times.

An interview with RN #145 on November 16, 2015, revealed that a scheduled toileting plan is when a resident is assisted with toileting at certain times. She further indicated that resident #003 is assisted with toileting before and after breakfast, and before and after lunch. The RN revealed that the written plan of care was updated on November 13, 2015, which indicates that the resident is to be toileted at 7:30 a.m., 10:00 a.m., 12:00 p.m., 2:30 p.m., 6:00 p.m., and 8:00 p.m.

A review of the written plan of care prior to November 13, 2015, and interviews with staff #142, #144, #145, and #136, confirmed that the written plan of care did not set out clear direction to staff who provide direct care to the resident in regards to continence care. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the substitute decision maker (SDM), has been provided the opportunity to participate fully in the development and implementation of the plan of care.

A record review of resident #020's chart revealed there was a note stating that the SDM of the resident is to be called for every change in the resident's health status. A review of the physician's order on an identified date, indicated the resident was ordered a medication to be administered twice a day.

An interview with RN #123 indicated when there is a change in medication orders, the family or SDM has to be notified and it has to be documented in the physician's order form, or progress notes. The RN further confirmed that resident #020's SDM was not notified about the new medication order on the identified date.

Interviews with RN #123 and resident #020's SDM confirmed that the SDM was not notified about the physician's order on the identified date, and had not been provided the opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)]

WN #4: 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 has failed to ensure that the policy "Drug Destruction and Disposal" is complied with.

Review of the policy "Drug Destruction and Disposal" dated January 2015, states all medications which become surplus due to expiry, illegible labels, discontinuation, change in order, resident death or discharge, containers not meeting requirements of Drug and Pharmacies Regulation Act or supplies that do not meet the requirements of the Long Term Care Homes Act 2007 O. Reg. 79/10, s.122 (1) (b) i.e. medications from the community are destroyed and disposed of, according to applicable legislation.

On November 13, 2015, at 1:00 p.m. the inspector observed a medication cart on an identified unit, contained a bottle with medications in the top drawer with an expiry date of October 2015.

An interview with RN #123 indicated the 15th of every month, the registered staff perform audits of the medication carts for expired medications, and confirmed that the bottle with expired medications had not been discarded as per home policy.[s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that height for every resident is measured annually.

A record review revealed that six residents on one of the units have not had their height measured annually in 2014.

An interview with Nutrition Manager (NM) #135 confirmed that the identified residents' did not have their heights measured in 2014.

An interview with the DON confirmed that the expectation is for residents' heights to be measured annually, and that the identified residents' heights were not measured in 2014. [s. 68. (2) (e) (i)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there are measures in place to prevent the transmission of infection.

A review of resident #003's current written care plan revealed that the resident had a specified diagnosis that was confirmed with lab result on an identified date.

On an identified date, the inspector observed that resident #003 was not on contact precautions.

Interviews with the PCA #140 and #136 revealed that they were not aware that resident #003 had the specified diagnosis and did not wear personal protective equipment (PPE) for contact precautions when providing direct resident care.

An interview with the IPAC lead revealed that he/she was not aware that resident #003 had a specified diagnosis.

A review of the home's policy "Infection Prevention and Control" (IC-0505-00, revised 01-04-15) indicated that contact precautions must be initiated upon receipt of a positive identified culture, staff must wear gloves and long-sleeved gown when providing direct care.

Interview with the DOC confirmed that upon receipt of a specific positive lab result for resident #003 contact precautions were not in place in order to prevent the transmission. [s. 86. (2) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the program is evaluated and updated at least annually in accordance with evidence-based practices.

The home’s policy "Tuberculosis Screening" (IC-0303-00), revised January 3, 2015, reveals that all residents admitted to the home are given a 2-step Mantoux skin test for tuberculosis, unless the resident has tested positive in the past in which case they will be evaluated for tuberculosis by chest x-ray.

An interview with the DON confirmed that the policy was not updated annually in accordance with evidence-based practice as identified in the Canadian Tuberculosis standards, 7th edition. [s. 229. (2) (d)]

2. The licensee has failed to ensure that there is a designated staff member to co-ordinate the infection prevention and control program with education in infection prevention and control practices including infectious diseases, cleaning and disinfection, data collection and trend analysis, reporting protocols, and outbreak management.

An interview with the current infection prevention and control (IPAC) lead, revealed that he/she has been an IPAC lead since October 2015, and that he/she has not commenced or completed IPAC education.

An interview with the Administrator revealed that the expectation is for the designated IPAC lead to have IPAC education and confirmed that the previous two IPAC leads in 2013, 2014 and 2015, did not complete IPAC education. [s. 229. (3)]

Issued on this 4th day of December, 2015

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

Original report signed by the inspector.