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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Jan 13, 2017	2016_432654_0010	032859-16	Complaint

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

SIMAR KAUR (654)

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): November 25, 29 and 30, 2016.

During the course of this inspection non-compliance was identified under s.19. (1) of the Long-Term Care Homes Act, 2007 (LTCHA, 2007).

Review of the home's Compliance History revealed a history of non-compliance related to the LTCHA, 2007, s. 19. (1). An order was issued under s. 19. (1) during Resident Quality Inspection (RQI), report # 2016_413500_0011 dated November 25, 2016, with a compliance due date January 27, 2017.

As per policy, a written notice (WN) has been issued under s. 19. (1) with additional evidence for the existing order not past-due.

During the course of the inspection, the inspector conducted a tour of the home, observed resident care, staff to resident interactions, and reviewed relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing, Nurse Manager, Behaviour Support Registered Nurse, Resident Assessment Instrument Minimum Data Set Coordinator, Registered Nurses, Registered Practical Nurses, Personal Care Assistant, Recreation staff, Social Worker, Resident and Family Member.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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. 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 :

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

Record review of resident #002's progress notes and the Resident Incident Report indicated that resident #002 exhibited an identified responsive behaviour toward resident #001 causing injury on an identified date.

Record review of resident #002's Resident Incident Reports and interview with RN #108 indicated that resident #002 had identified responsive behaviours towards co-residents and staff. Further review of the Incident reports and interview with RN #108 indicated that resident #002's had exhibited identified responsive behaviours toward co-residents on three identified dates between identified periods of time.

Record review of resident #002's written plan of care, indicated identified interventions for the identified responsive behaviours which directed staff to refer to an identified consultation, and start resident #002 on an identified specific monitoring.

Record review of resident #002's heath record indicated that there was no record of the specific monitoring after the above mentioned incident with resident #001 on the identified above mentioned date. Further record review revealed that there was no record of a referral to the identified consultation after the above mentioned three identified incidents prior to the incident with resident #001.

Interview with RN #108 confirmed that he/she was the nurse in charge on the identified day, during the incident between residents #002 and #001. RN #108 further confirmed that he/she did not initiate the identified monitoring for resident #002 as directed in resident #002's plan of care.

Interview with the Behaviour Support Nurse #112 confirmed that he/she had not received a referral for resident #002's responsive behaviors. Further interview with Behavior Support Nurse #112 and RN#113 revealed that a referral was not sent, and resident #002 was not assessed by the identified consultation team after the incidents identified above.

Record review of the home's policy titled Behavioral Response- Care strategies: Modified Dementia Observation (DOS) (Section 05-Resident Planning Process, Dated: 01-03-2015) indicated the following procedures:
-Complete DOS Modified Dementia Observation as a component of the assessment for new or escalating behaviors in order to gain a better insight and understanding of the time, pattern and antecedents leading to behavioral response when the root cause or triggers are difficult to identify.
- Refer to the Behavioral Support Nurse/Community resources for further assessments and insight into behaviors.

Interview with the DON confirmed that staff are expected to provide care according to the residents plan of care, and further confirmed that interventions identified in resident #002's plan of care for his/her responsive behaviours were not implemented.

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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including Identifying and implementing interventions, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee has failed to ensure that all residents were protected from abuse by anyone.

Review of the Ministry of Health and Long Term Care (MOHLTC)'s Critical Incidents System identified a CI report indicated resident to resident abuse.

Record review of resident #001's progress notes and the identified CI report revealed that on an identified date and time, resident #002 and resident #001 were sitting beside each other. Recreation staff #106 overheard a conversation between resident #001 and #002 and intervened. A few seconds later staff #106 observed resident #002 had approached resident #001. Staff #106 called out to both residents to stop. Resident #001 got up and left. PCA #111 observed resident #001 in the hallway and noted that resident #001 had been injuired.

Record review of resident #002's plan of care indicated a history of responsive behaviors. Further record review of resident #002's progress notes revealed multiple occasions when resident #002 had exhibited identified responsive behaviours toward co-residents and staff.

Review of resident #002's Incident Reports and interview with RN #108 indicated three identified incidents of resident #002's identified responsive behaviours toward co-residents were reported between identified periods of time.

Record review of resident #002's written plan of care on an identified date indicated identified interventions for responsive behaviours included staff to refer to an identified consultation. Record review of resident #002's health records revealed that there was no record of a referral to the identified consultation for the incidents of responsive

behaviours on three identified dates.

Interview with Behavior Support Nurse #112 and RN#113 revealed that a referral was not sent, and resident #002 was not assessed by the identified consultation team after his/her incidents of identified responsive behaviours on three identified dates.

Interview with resident #001 stated that he/she had an injury from another resident. The resident further stated that the injury caused a lot of discomfort and pain.

Interview with recreation staff #106 indicated that he/she witnessed on the above mentioned identified date, that resident #001 screamed when resident #002 exhibited an identified abuse toward resident #001. Interview with PCA #111 confirmed that after the identified abuse from resident #002 towards resident #001, he/she observed the altered skin areas on resident #001's identified area of body. RN #108 revealed in an interview that the police were called by the home on an identified date, in response to the incident of resident to resident abuse. A police officer came to the home on another identified date, and did not press charges against resident #002.

Interview with the DON, RN #108, Nurse Manager #113, recreation staff #106 and PCA #111 revealed that resident #002's identified abuse to resident #001 during the incident on the identified date as mentioned above.

The scope of this non-compliance was isolated to one resident. The severity was actual harm/risk.

A review of the compliance history revealed a history of non-compliance related to the LTCHA, 2007, s. 19. (1). An order was issued under s. 19. (1) during Resident Quality Inspection (RQI), report # 2016_413500_0011 dated November 25, 2016, with a compliance due date January 27, 2017.

As per policy, a written notice (WN) has been issued under s. 19. (1) with additional evidence for the existing order not past-due. [s. 19. (1)]

Issued on this 13th day of February, 2017

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

Original report signed by the inspector.