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 prévue 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**

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


**Public Copy/Copie du public**

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Apr 10, 2019 | 2019_616722_0006 | 008651-17, 020173-17, 000038-18, 000086-18, 000534-18, 001438-18, 000460-19 | Critical Incident System |

**Licensee/Titulaire de permis**

City of Toronto
365 Bloor Street East 15th Floor TORONTO ON M4W 3L4

**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**

COREY GREEN (722), CHAD CAMPS (609), JADY NUGENT (734)

## 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): April 1-5, 2019.**

**The following critical incidents were inspected:**
**- Four (4) incidents related to falls that resulted in injury.**
**- Two (2) incidents related to allegations of staff-to-resident abuse.**
**- One (1) incident related to an unexpected death.**

**This inspection was completed concurrently with complaint inspection #2019_616722_0005.**

**During the course of the inspection, the inspector(s) spoke with the Acting Director of Nursing (ADON), the Medical Director, Nurse Managers, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.**

**The inspectors also made observations of residents and resident home areas, and reviewed relevant administrative and health records for specified residents.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Hospitalization and Change in Condition**
**Nutrition and Hydration**
**Prevention of Abuse, Neglect and Retaliation**

**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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident (CI) report was submitted by the home to the Director on a specified date, for a fall involving resident #005 that occurred on a specified date, where the resident sustained an injury.

During an interview with Inspector #734, RPN #104 verified that they were present and working on the specified date when the resident fell. The RPN explained that they saw the resident and asked the resident to have a seat. The RPN indicated that they observed the resident fall, and did not provide assistance to the resident as specified in the plan of care.

Inspector #734 reviewed the progress notes in the resident's health care records, which confirmed that the resident had sustained a fall on the specified date, and that the resident sustained an injury. Inspector #734 reviewed the resident's care plan in effect at the time of the fall, which indicated specified interventions related to locomotion on the unit and assistance when sitting in a chair.

Inspector #734 reviewed the home's policy entitled "Nursing and Personal Care Records," published January 1, 2019, which indicated the following: "Nursing and personal care shall be delivered and documented following the resident's Plan of Care."

During an interview with Inspector #734, RPN #126 verified that, according to the care plan, the resident was supposed to receive specified assistance when sitting in a chair.

The ADON was interviewed by Inspector #734, and verified that RPN #104 should have provided assistance to the resident to be seated in the chair, as per the resident's plan of care. [s. 6. (7)]

2. The licensee failed to ensure that the provision of the care set out in the plan of care was documented.

A CI report was submitted by the home to the Director on a specified date, for a fall involving resident #007 that occurred on a specified date and that resulted in an injury.

Inspector #734 reviewed the resident's health care record related to the fall, and was unable to locate the Post Fall Assessment Huddle Form for the fall.

Inspector #734 reviewed the home's policy entitled "Fall Prevention and Management," published October 1, 2016, which indicated the following under C. Post Fall Management: "7. Conduct Post Fall Assessment Huddle meeting with the interdisciplinary Care Team present on the unit at the time of the fall…Document the meeting on the Post Fall Assessment Huddle Form and place in chronological order in the section of Health Care Record in Progress Notes."

Inspector #734 reviewed the home's policy entitled "Nursing and Personal Care Records," published January 1, 2019, which indicated the following: "Nursing and personal care shall be delivered and documented following the resident's Plan of Care."

During an interview with Inspector #734, RPN #124 indicated that a Post Fall Assessment Huddle was to be conducted after any resident has had a fall in the home and documented on the Post Fall Assessment Huddle Form.

During an interview with Inspector #734, RN #116, a nurse manager, was unable to locate a completed Post Fall Assessment Huddle Form for the resident's fall. RN #116 verified that the Post Fall Assessment Huddle Form should have been completed after the fall.

Inspector #734 interviewed the ADON, and they were also unable to locate a completed Post Fall Assessment Huddle Form for the resident related to this fall. The ADON acknowledged that the Post Fall Assessment Huddle Form should have been completed after the fall. [s. 6. (9)]

***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, to be implemented voluntarily.***

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**WN #2: 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 were kept closed and locked when they were not being supervised by staff.

On a specified date and time, Inspector #609 observed a towel in the door latch to a specified electrical room, which was preventing the door from locking. A sign on the door indicated that the room was to be kept locked at all times. Inspector #609 observed that there were no staff members or workers inside the room, that the electrical box was open, and wires were noted on the floor.

A review of the home's policy entitled "Door Security," published January 8, 2015, indicated that all doors leading to non-residential areas must be kept closed and locked when they were not being supervised by staff.

During an interview with Inspector #609, PSW #115 indicated that electrical workers were working in the room, and must have placed the towel into the door latch to stop it from locking. The PSW verified that the room should have been locked when not in use. PSW #115 removed the towel and locked the door to the room.

During separate interviews with Inspector #609, RN #114 and #115, both nurse managers, verified that the door to the specified room should have been closed and locked when unattended and that this did not occur on the specified date, when a towel was identified in the latch of the door to prevent it from locking.

The licensee failed to ensure that the door to the specified room, a non-residential area, was kept closed and locked on the specified date, when not being supervised by staff. [s. 9. (1) 2.]

**Issued on this 10th day of April, 2019**

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

**Original report signed by the inspector.**