Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Mar 04, 2021	2021_650565_0001 (A1)	001755-20, 001815-20, 015730-20, 000498-21	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
Seniors Services and Long-Term Care (Union Station) c/o 55 John Street 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

Amended by MATTHEW CHIU (565) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

This licensee inspection report has been revised to reflect the corrected resident #s. The Critical Incident System inspection, #2021_650565_0001 was completed on January 15, 18-22 and 25-27, 2021.
A copy of the revised report is attached.

Issued on this 4 th day of March, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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

Amended by MATTHEW CHIU (565) - (A1)

Amended 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): January 15, 18-22 and 25-27, 2021.

The following intakes were completed in this Critical Incident System (CIS) inspection:

Log #001755-20; Log #001815-20 related to follow up to Compliance Orders;

Log #015730-20 related to medication administration; and

Log #000498-21 related to infection prevention and control.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nurse Managers Clinical (NMCs), Counsellor, Physician, Medical Director (MD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Care Aides (PCAs), Residents, and Family Members.

During the course of the inspection, the inspectors conducted a tour of the resident home areas, observed resident and staff interactions, and reviewed clinical health records, relevant policies and procedures, and other documents.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Medication
Personal Support Services

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

1 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 36.	CO #001	2019_767643_0035	565
O.Reg 79/10 s. 50. (2)	CO #001	2019_767643_0036	210

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	Légende 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. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (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 to the extent possible in the development and implementation of the resident’s care plan, and in reviews and revisions of the care plan. O. Reg. 79/10, s. 24 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #009, #011, and #012, their substitute decision-makers, if any, and any other persons designated by the residents or substitute decision-makers were given an opportunity to participate to the extent possible in the development and implementation of the residents' care plans, and in reviews and revisions of the care plan.

On the admission day for resident #009 and the following day, the home had provided the resident with incorrect medical treatment. The resident was transferred to the hospital for monitoring and returned to the home with no change in their condition.

The resident's substitute decision-makers (SDM) was with the resident during the admission process. A RN created the medical treatment order for the resident based on their admission records and did not review the medical treatment with the resident's SDM. The next day, the resident's SDM called the home to clarify the medical treatment, and the home found out an error was made during the admission process.

The process for creating the medical treatment order during admission was reviewed for residents #011 and #012. Registered staff were not able to confirm that the medical treatment orders for these residents were reviewed with the residents or the residents' SDMs.

The home's policy related to the development of the medical treatment orders for new admissions stated the procedures, involving the residents or their SDMs, for the home staff to create the orders. During the admissions for residents #009, #011, and #012, the residents or their SDMs were not involved in the required procedures for the development of the residents' medical treatment orders.

Sources: CIS report; residents' clinical record; home's policy; interviews with registered nurses and other staff. [s. 24. (5)]

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 resident, the resident's substitute decision-makers, if any, and any other persons designated by the residents or substitute decision-makers are given an opportunity to participate to the extent possible in the development and implementation of the resident's care plan, and in reviews and revisions of the care plan, to be implemented voluntarily.

Issued on this 4 th day of March, 2021 (A1)

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

Original report signed by the inspector.