Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: April 14, 2023	
Inspection Number: 2023-1538-0002	
Inspection Type: Critical Incident System	
Licensee: City of Toronto	
Long Term Care Home and City: Cummer Lodge, North York	
Lead Inspector Henry Chong (740836)	**Inspector Digital Signature**
Additional Inspector(s) Kehinde Sangill (741670)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):
March 24, 27-31, 2023

The following intake(s) were inspected:

- Intake: #00005049 - [CI: M512-000028-21] - Resident to resident physical abuse
- Intake: #00019484 - [CI: M512-000003-23] - Unexpected death
- Intake: #00019771 - [CI: M512-000004-23] - Medication incident/adverse drug reaction
- Intake: #00022415 - [CI: M512-000007-23] - Fall with injury

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

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INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed ensure any standard or protocol issued by the Director with respect to IPAC was implemented.

Specifically, the licensee failed to ensure that point-of care signage indicating that enhanced IPAC control measures are in place, as required by Additional Precautions 9.1 (e) as required by additional precautions under the IPAC standard.

Rationale and Summary
On an identified date, a staff member was observed entering a resident's room on droplet/contact precautions. An enhanced precautions sign was posted on the door indicating the specific personal protective equipment (PPE) to be worn by staff, including mask, gloves, gown and eye protection. The staff member wore a surgical mask, gloves, and gown prior to entering the room, but did not wear eye protection.

The RN and Infection Prevention and Control (IPAC) Practitioner stated the resident was currently on contact precautions, and that the signage was incorrect. The RN subsequently updated and replaced the signage on the resident's door to contact precautions, including the correct PPE to be worn by staff on the same day.

Sources: Observations; and interviews with IPAC Practitioner and other staff.

[740836]

Date Remedy Implemented: March 24, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 102 (7) 11.

The licensee has failed to ensure that their hand hygiene program was implemented in accordance with any standard issued by the Director.

Specifically, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s. 10.1 states that the licensee shall ensure that the hand hygiene program included access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR).

Rationale and Summary
On an identified date, one bottle of expired ABHR was observed in the home. A staff member was informed and stated the product should not be used and discarded the bottle immediately. On the same day, three bottles of expired ABHR were observed in a different area in the home. The IPAC Practitioner was informed and immediately discarded the products. The IPAC Practitioner acknowledged that the expired products should not be in use as they will not be effective.

Sources: Observations; and interviews with IPAC Practitioner and other staff.

[740836]

Date Remedy Implemented: March 24, 2023

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 19 (1)

The licensee has failed to ensure that resident #001 is protected from physical abuse by resident #002.

Section 2 (1) of the Ontario Regulation 79/10 defines physical abuse as “the use of physical force by a resident that causes physical injury to another resident."

Rationale and Summary
On an identified date, resident #001 and resident #002 were involved in a physical altercation. Resident #002 sustained an injury. The residents were immediately separated.

A staff member stated that they witnessed the physical altercation between resident #001 and resident #002. Resident #001 was treated for injury.

The Director of Care said that physical abuse occurred as there was injury to the resident.

Sources: CIS report M512-00008-21; resident #001 and resident #002's clinical records; and interviews with Director of Care and other staff.

[740836]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)

The licensee has failed to ensure that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

Rationale and Summary
A resident required a type of assistance with meals. On an identified date, the resident was provided their meal and left alone without anyone to provide them with their required assistance.

Staff acknowledged that they left the resident to eat alone because they did not check the care plan for the level of assistance the resident required with meals.

The Tray Service policy required the staff to monitor the resident during meal service and provide assistance as per their care plan.

The Registered Dietitian (RD) #116 stated that the resident had risk factors that predisposed them to further harm if they did not receive assistance from the staff during their meal.

The NM #113 and the DOC stated that the resident should not have been left to eat alone during tray service.

Sources: Review of Tray Service policy (RC-0523-21, published August 15, 2022); the LTCH’s investigation notes; resident’s clinical records; and interviews with RD #116, NM #113, the DOC and other staff.

[741670]

WRITTEN NOTIFICATION: Security of drug supply

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 2. i.

The licensee has failed to ensure that a resident did not have access to restricted areas containing drug supply.

Rationale and Summary
On an identified date, narcotics were discovered to be missing during a medication count by RPN #110 and RPN #112 at shift change.

The investigation notes indicated that video footage was reviewed by Nursing Manager (NM) #113 and the Director of Care (DOC), which revealed on an identified date, RPN #112 took the narcotics to the nursing station counter and counted them alone. Shortly after, RPN #112 left the narcotics unattended. A resident was sitting near the nursing station and obtained the narcotics, and then placed the box back.

The licensee's policy "Narcotics and Controlled Medications" directed staff to ensure the safe and secure practices of narcotics and controlled substances, including the storage, handling, monitoring, and documenting of medications.

RPN #112 stated that they counted the narcotics and controlled substances at the nursing station and that they are to count narcotics and controlled medications in the medication room with two nurses present. NM #113 and the DOC said that staff did not complete the medication count appropriately and that a resident accessed the narcotics. The DOC stated that the resident took the narcotics and then put the box back without knowledge from the staff. Interviews with staff revealed that the missing narcotics were not found, and that there were no changes to the resident's health.

There was risk to the resident's health as they were able to access a supply of narcotics when staff left the medication unattended in an accessible area.

Sources: CIS report M512-00004-23, home's investigation notes; licensee's policy "Narcotics and

Controlled Medications, MM-0106-00", published 15-09-2022; and interviews with RPN #112, Nursing Manager #113, Director of Care, and other staff.

[740836]

COMPLIANCE ORDER CO #001 Plan of Care

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Retrain staff #117 on the process to review residents' plan of care related to diet orders prior to providing resident care;

2. Maintain a record of the training provided, including the date, who conducted the training and contents of the training that was provided;

3. Conduct audits on five residents who are assessed as high nutritional risk and require modified texture diet on an identified home area to ensure appropriate diet texture is provided at meals. The audits are to be conducted at breakfast, lunch, and supper for a period of seven days following the service of this order;

4. Conduct an audit, at minimum of once daily for one resident who has been assessed at moderate or high risk for falls on an identified home area, to ensure that falls prevention interventions are in place as per the resident's plan of care. Audits shall be conducted for a period of seven days following the service of this order, with a different resident audited each day;

5. Maintain a record of the above audits, including the date and time, who conducted the audit, residents audited, results of each audit and actions taken in response to the audit findings.

Grounds

a) The licensee has failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in the plan.

Rationale and Summary
A resident had a fall and was transferred to the hospital and diagnosed with an injury. Their plan of care specified a falls prevention intervention to be in place when the resident utilized a certain device.

On an identified date, the resident was observed using the device without the falls prevention intervention in place. Staff interviews confirmed that when the resident was using the device, the falls prevention intervention should be in place. Failure to provide the intervention may put the resident at further risk of harm from a fall.

Sources: Resident's care plan; observations; and interviews with staff.

[740836]

b) The licensee has failed to ensure that the care set out in the plan of care was provided to a resident, related to diet order.

Rationale and Summary

On an identified date, a resident complained of difficulty eating their meal. Their diet texture was changed to mitigate the potential risk of harm from their meal.

On a later date, a staff member provided food with the incorrect diet texture for the resident. The staff member indicated that they were not aware that the resident's diet order had changed as they did not review the resident's plan of care.

The Registered Dietitian (RD) #116 verified that the resident had risk factors identified with their meals and their diet texture was changed to mitigate this risk.

The Nurse Manager (NM) #113 and Director of Care (DOC) acknowledged that the staff member should have verified the resident's diet order in the care plan before providing the food.

Failure to provide the resident with the correct diet texture put them at risk for harm.

Sources: Review of CIS #M512-000003-23; the home's investigation notes; resident's clinical records; and interviews with RD #116, NM #113, DOC and other staff.

[741670]

This order must be complied with by May 29, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.