Ontario

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

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

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

Original Public Report

Report Issue Date: August 24, 2023

Inspection Number: 2023-1538-0004

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: City of Toronto

Long Term Care Home and City: Cummer Lodge, North York

Lead Inspector	**Inspector Digital Signature**
Dorothy Afriyie (000709)	Dorothy A Afriyie Digitally signed by Dorothy A Afriyie Date: 2023.08.25 12:16:59 -04'00'

Additional Inspector(s)
Henry Chong (740836)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 8-10, 14-16, 2023
The inspection occurred offsite on the following date(s): August 11, 2023

The following intake(s) were inspected:

- Intake: #00090708 - Follow-up related to Transferring and Positioning
- Intake: #00090880 - [M512-000022-23] - Unwitnessed fall with injury
- Intake: #00092644 - [M512-000025-23] - Fracture not related to fall
- Intake: #00092692 - [M512-000026-23] - Acute Respiratory Illness Outbreak
- Intake: #00093530 - Complainant related to improper transfer

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1538-0003 related to O. Reg. 246/22, s. 40 inspected by Henry Chong (740836)

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Unsafe Transferring Techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that safe transferring techniques were used by staff when assisting a resident.

Rationale and Summary:
PSW #106 and #109 assisted a resident from a mobility device to their bed in an unsafe manner. Resident's care plan indicated another form of transfer used by the resident. A Physiotherapist confirmed the directions related to this resident's transfer on the care plan was correct. PSW #106 stated they were not aware of the resident's care planned transfer status. A Nurse Manager verified that the Long-Term Care Home has procedures in place to ensure safe resident transfers and that this resident was unsafely transferred in a manner inconsistent with their care planned needs and the home's policies and procedures. Failure to use a safe transferring technique when assisting the resident increased the risk of injury for the resident.

Sources: Resident healthcare record; interviews with PSW #106 and #109 and Nurse manager; Home Policy # RC-0522-09, published 01-01-2015

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WRITTEN NOTIFICATION: Pain Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, they were assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary:
A Critical incident report was submitted by the home. A resident stated there was a concern related to their transfer from a mobility device to their bed and complained of pain. As a result of this, a RPN provided an intervention to the resident. However, the pain was not relieved. The home's pain assessment and management policy indicated to assess the resident using the Abbey pain scale assessment tool when the resident requested for pain interventions. The RPN did not complete the pain assessment tool when the resident's pain was not relieved by initial interventions. The Nurse Manager stated that the resident should have been assessed using the pain assessment tool when the pain intervention was ineffective. Failure to ensure that the resident pain was assessed using a clinically appropriate assessment instrument after initial interventions were ineffective led to the resident having unrelieved pain.

Sources: Resident clinical records; Interviews with RPN and Nurse Manager; Home's Pain Assessment and Management Policy # RC-0518-01, Published 01-02-2020

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