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
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Original Public Report

Report Issue Date: September 20, 2024.

Inspection Number: 2024-1538-0004

Inspection Type:
Complaint
Critical Incident

Licensee: City of Toronto

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 3-6, and 9-11, 2024.

The following Critical Incident (CI) intake(s) were inspected:

- Intake #00118072-CI #M512-000024-24 was related to responsive behaviors.
- Intake #00120737-CI #M512-000027-24 was related to fall prevention and management.
- Intakes #00121051-CI #M512-000028-24 and #00124923-CI #M512-000035-24 were related to infection prevention and control.
- Intake #00121719-CI #M512-000031-24 related to resident care and support services.

The following Complaint intakes were inspected:

- Complaint intake #00121826 was related to admission, absences and discharge.
- Complaint intake #00121886 was related to resident care and support services.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Authorization for admission to a home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (7) (b)
Authorization for admission to a home
s. 51 (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 50 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or

The licensee has failed to comply with FLTCA 2021 s. 51 (7) (b) whereby the licensee refused applicant's admission to the home based on reasons that are not permitted in the legislation.

Specifically, the licensee withheld approval for admission citing the staff of the home lacked the nursing expertise.

Rationale and Summary

The Ministry of Long-Term Care received a complaint related to bed refusal from the home due to the applicant's specific care requirement.

The Director Of Care (DOC) stated the home had previous experience with supporting a resident with a similar care requirement and acknowledged the home did have the nursing expertise and resources needed to care for the applicant's specific care requirement.

By the home withholding their approval for admission without the appropriate grounds, this impacted the applicant's potential transition to a long-term care home (LTCH).

Sources: Applicant's Home and Community Care Support Services (HCCSS) application records, applicant's withholding of approval letter and, interviews with the Administrator and DOC.

WRITTEN NOTIFICATION: Written notice if licensee withholds approval

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (9) (c)
Authorization for admission to a home
s. 51 (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,

(c) an explanation of how the supporting facts justify the decision to withhold approval; and

The licensee has failed to ensure that when the licensee withheld approval for admission, they gave the applicant a written notice setting out an explanation of how the supporting facts justify the decision to withhold approval.

Rationale and Summary

A letter issued to the applicant only indicated the approval for admission to the home had been withheld on the grounds the home could not accommodate their specific care requirement. The Administrator acknowledged the supporting facts to justify the decision to withhold approval for admission were not explained in the letter.

Failure to provide the supporting facts for withholding approval put the applicant at risk of delayed placement into a long term care home.

Sources: withholding of approval letter and, interview with the Administrator.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that safe transferring techniques were followed when a non-staff member assisted with transferring a resident using a transferring device.

Rationale and Summary

A resident was transferred from one surface to another using a transferring device by a PSW and a non-staff member. The home's policy indicated that two nursing staff which include a Registered Nurse, Registered Practical Nurse, or Personal Support worker, are required to operate all transferring devices.

Nurse Manager (NM) verified non-staff members are not provided training on transferring devices, and therefore cannot assist with safely transferring residents.

The home failed to ensure that the staff complied with the home's policy related to the use of transferring devices when they had a non-staff member assist with transferring, which could place the resident's at a safety risk.

Sources: Home's Investigation Notes; Home's policy, Interviews with PSW and other relevant staff.

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. 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,
(b) identifying and implementing interventions.

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.

Rationale and Summary

There was an altercation where a resident struck another resident, and they injured that resident.

Personal Support Worker (PSW), Registered Practical Nurse (RPN) and RPN stated they were aware of the resident's responsive behaviours and sometimes their responsive behaviors would trigger other residents to become angry with them, they especially triggered a negative reaction from a specific resident.

The specified resident's plan of care did not identify that the other resident's responsive behaviours towards them would trigger them. There were no assessments done for the specified resident, nor interventions implemented for that resident to help staff minimize and prevent potentially harmful interactions or altercations between them.

BSO Lead stated there were no identified interventions after two previous incidents of noted near altercations, and that no steps were taken, such as a BSO referral, after each of those incidents to minimize potentially harmful interactions between these two residents.
Staff failed to identify and implement interventions when both residents continued to have harmful interactions between each other, which resulted in the resident

getting injured on that specified date.

Sources: residents' clinical records, interviews with PSW and other relevant staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (11) (a)
Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,
(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts; and

The licensee has failed to ensure that the home complied with the outbreak management system, related to reporting requirements.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies and protocols were developed for the outbreak management system and that they were complied with. Specifically, staff did not comply with the licensee's policy related to timely outbreak reporting to Toronto Public Health.

Rationale and Summary

On a specified date, residents on the same unit developed particular symptoms. Toronto Public Health was notified the following day, and a specific outbreak was

declared on a specified date.

The IPAC Manager stated that suspected specific outbreaks are to be immediately reported to Toronto Public Health.

Failure to immediately report the suspected respiratory infection outbreak to Toronto Public Health increased the risk of delays in the implementation of infection control directions from Toronto Public Health.

Sources: Review of the specific Outbreak Line List and the home's policy; interviews with IPAC Manager.

WRITTEN NOTIFICATION: Administration of drugs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure a specific medication was administered to the resident in accordance with the directions for use specified by the prescriber on a specified date.

Rationale and Summary

On a specified date, the resident's specific medication was administered by the RPN in the morning. The RPN was notified that the specified medication should have

been administered at bedtime.

The RPN confirmed that the medication was administered at the incorrect time as they failed to verify the administration time.

Failure of staff administering the medication at the prescribed time potentially decreased the efficacy of the medication for the resident.

Sources: Resident's clinical records; Interviews with RPN and other relevant staff.