



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division Performance Improvement and Compliance Branch

Toronto Service Area Office 55 St. Clair Avenue West, 8th Floor TORONTO, ON, M4V-2Y7

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Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: Jun 11, 12, 13, 14, 15, 2012; 2012_078202_0017; Complaint

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES 55 JOHN STREET, METRO HALL, 11th FLOOR, 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

VALERIE JOHNSTON (202)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Assistant Administrator, Nurse Managers, Registered Staff, Personal Care Aides, Private Care Giver

During the course of the inspection, the inspector(s) observed the provision of care to residents, reviewed clinical health records, reviewed home policies Falls Prevention and Management and Management of Pain: Assessment, Goals, Strategies and Evaluation

The following Inspection Protocols were used during this inspection:

Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 subsections:

- s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
- (a) a goal in the plan is met;
 - (b) the resident's care needs change or care set out in the plan is no longer necessary; or
 - (c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that resident A and resident B were reassessed and the plan of care reviewed and revised when the care set out in the plan of care had not been effective. [s.6.(10)(c)]

Resident A's written plan of care identifies this resident as high risk for falls, uses a wheelchair for ambulation and requires staff assistance for all transfers.

Clinical record review for resident A indicated that this resident fell on December 31, 2011, January 26, February 08, 17, March 21, 27, April 21, 30, May 01 at 15:45 hours and 17:15 hours, May 15, 28, and June 09, 2012. Clinical record review and staff interview revealed that resident A was not reassessed or the care plan reviewed and revised when the care set out in the plan of care had not been effective. [s.6.(10)(c)]

Resident B's written plan of care identifies this resident as high risk for falls, uses a wheelchair for ambulation and requires staff assistance for all transfers.

Clinical record review for resident B revealed that this resident fell on January 17, 25, 28, February 1, 3, 4, 7, 10, 25, 26, March 03, 10, 14, 26, 26, April 09, 30, May 21, 23, 28, 2012. Staff interview and clinical record review revealed that resident B was not reassessed or the care plan reviewed and revised when the care set out in the plan of care had not been effective. [s.6.(10)(c)].

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 residents are reassessed and the care plan reviewed and revised when the care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following subsections:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's Falls Prevention and Management Policy RC-0518-21 March 01, 2012 is implemented and complied with. [s.8.(1)(a)(b)]

The home's written policy Falls Prevention and Management RC-0518-21 March 01, 2012 directs staff to complete a Post Fall Assessment Huddle after a resident has fallen and to document the resident's health status every 8 hours for 24 hours proceeding a fall.

Through staff interviews it was identified that staff had no knowledge that a Post Fall Assessment Huddle was to be completed for each resident that has fallen as directed in the home's Falls Prevention and Management policy RC-0518-21 March 01, 2012.[s.8.(1)(a)]

The Nurse Manager revealed in an interview that the Post Fall Assessment Huddle had not been implemented in the home in accordance to home's Falls Prevention and Management policy RC-0518-21 March 01, 2012. [s.8.(1)(a)].

Clinical record review and staff interview revealed that resident's health status post fall has not been documented every 8 hours for 24 hours after a resident has fallen in accordance to the home's Falls Prevention and Management policy. [s.8.(1)(b)]

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 the home's Falls Prevention and Management policy is put in place and complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management
Specifically failed to comply with the following subsections:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident has fallen is assessed and a post-fall assessment conducted using a clinically appropriate assessment instrument that is specifically designed for falls. [s.49.(2)].

Resident A's written plan of care identifies this resident as high risk for falls, uses a wheelchair for ambulation and requires staff assistance for all transfers.

Clinical record review for resident A indicated that he fell on December 31, 2011, January 26, February 08, 17, March 21, 27, April 21, 30, May 01 at 15:45 hours and 17:15 hours, May 15, 28, and June 09, 2012. Clinical record review and staff interview revealed that resident A was not assessed after any fall using a clinically appropriate assessment instrument specifically designed for falls. [s.49.(2)].

Resident B's written plan of care identifies this resident as high risk for falls, uses a wheelchair for ambulation and requires staff assistance for all transfers.

Clinical record review for resident B revealed that this resident fell on January 17, 25, 28, February 1, 3, 4, 7, 10, 25, 26, March 03, 10, 14, 26, 26, April 09, 30, May 21, 23, 28, 2012. Clinical record review and staff interview revealed that resident B was not assessed after any fall using a clinically appropriate assessment instrument specifically designed for falls.

Resident C's written plan of care identifies this resident as having an unsteady gait, uses a walker for ambulation and requires staff assistance for all transfers.

Clinical record review for resident C revealed that this resident fell on April 29, May 31, and June 10, 2012. Clinical record review and staff interview revealed that resident C was not assessed after any fall using a clinically appropriate assessment instrument specifically designed for falls.[s.49.(2)]

An interview with the Nurse Manager confirmed that the home has not implemented a clinically appropriate assessment instrument specifically designed for falls. [s.49.(2)]

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 when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 15th day of June, 2012

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

