Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 15, 2017	2017_635600_0008	019886-16, 020341-16, 021232-16, 022156-16, 022558-16, 023592-16, 025225-16, 025233-16, 027319-16, 027859-16, 028300-16, 028827-16, 029378-16, 029769-16, 030101-16, 030630-16, 031785-16, 031895-16, 034186-16, 034816-16, 034954-16, 000238-17, 000342-17, 001493-17, 003412-17	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
55 JOHN STREET METRO HALL, 11th FLOOR TORONTO ON M5V 3C6

Long-Term Care Home/Foyer de soins de longue durée

CASTLEVIEW WYCHWOOD TOWERS
351 CHRISTIE STREET TORONTO ON M6G 3C3

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

GORDANA KRSTEVSKA (600), IVY LAM (646), MATTHEW CHIU (565)

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): March 9, 10, 13, 14, 15, 16, 17, 20, 21, 22, 23, 24, 27, 28, 29, 30, 31, April 3, 4, 5, 6, 7, 10, 11, 12, 13, 18, 19, 20, 21, 24, 25, 26, 27, and 28, 2017.

During the critical incident inspection #2017_635600_0008 the following Critical Incident (CI) intakes were inspected
Related to Duty to Protect:
019886-16, 021232-16, 023592-16, 025233-16, 025225-16, 028827-16, 030630-16, 034186-16, 30101-16, 030630-16, 001493-17, 022558-16, 028300-16, 29378-16, 028300 -16, 031895-16, 000238-17, 003412-17, 029769-16,
Related to Safe and Secure Home: 003412-17, 020341-16,
Related to Falls Prevention and Management: 022156-16; 031785-16, 034816-16, 034954-16; 027859-16, 027319-16.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Assistant Administrator, Director of Nursing (DON), Nurse Managers (NMs), Acting NM, Physician, Food and Nutrition Duty Manager, Geriatric Mental Health Outreach Team (GMHOT) consultant, Behavioural Supports Ontario (BSO) Lead, Physiotherapist (PT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Care Aid (PCA), food servery workers, Substitute Decision Maker (SDM), housekeeping staff, and residents.

During the course of the inspection, the inspectors observed the provision of care, reviewed clinical records, staff education records, Critical Incident System record, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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

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

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	Legendé 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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A critical incident (CI) report was received by the Director on an identified date related to an incident that resulted in a significant change in the resident's condition.

Review of resident #004's progress note from an identified date revealed that Personal Care Aid (PCA) #138 reported to Registered Practical Nurse (RPN) #139, that while providing care to resident #004, tried to assist the resident in one of the activities of daily living (ADL), the resident suddenly refused to participate in the process. The PCA assisted to resident to change the resident position from standing up to sitting on the floor. The RPN had not identified any injury at that time and he/she decided to closely monitor the resident. Further review of the resident's progress notes revealed that on the following day, the substitute decision maker (SDM) visited the resident and the resident told him/her that he/she had an incident the previous day and had a discomfort to his/her identified area of the body. The SDM reported to the RPN who called the physician and he/she ordered a diagnostic procedure. The procedure was completed the same day, however on the following day the resident #004 was called again for further assessment and treatments as the diagnostic procedure had identified injury of the resident's identified area of the body.

Review of resident #004's minimum data set (MDS) assessment from an identified date and the written plan of care last updated on a specified date indicated the resident needed extensive, weight bearing assistance by two staff with an identified ADL.

Interview with the PCA #138 revealed that on the identified date, while assisting resident #004 with one of the ADLs, the resident suddenly stood up on his/her feet and grabbed the bedside rail with a left hand and the bedside table with a right hand. Further, the PCA confirmed that when the resident stood up holding on to the bedside rail and the night stand the PCA insisted the resident to go back to bed, but the resident refused. The PCA

stated that somehow he/she managed to change the position of the resident from standing up to sitting on the floor and went to seek assistance.

Interview with Nurse Manager (NM) #119 confirmed that the staff is expected to assess the resident's condition and ability for transfer and include safe techniques while transferring the residents. [s. 36.]

2. A CI report was received by the Director on an identified date related to an incident that caused an injury to the resident which resulted in a significant change in resident #009's health condition.

Review of CI report revealed series of events happened to resident #009:
On an identified date – change in a condition of an identified area of resident's body;
The following day - a physician assessed the resident regarding the changes in the identified area of the body and ordered a diagnostic procedure;
The next day, staff noted significant change of another identified area of the body; the resident was assessed by the physician and ordered another diagnostic procedure;
Three days after the procedure, the home received report from the diagnostic department regarding some changes of the first identified area of the body and significant changes to the second identified area of the body.

Review of resident #009's chart revealed that resident was admitted to the home with an identified health condition. The resident was identified to need assistance by staff to make decisions for daily living and physical assistance by staff for all ADLs.

Review of the resident's progress notes on an identified date revealed that the evening nurse noted resident #009 to have changed condition to an identified area of the body. The resident also had been complaining of discomfort to the identified area during care provided. On the next day the physician assessed the resident, prescribed a treatment and referred the resident for a diagnostic procedure considering the existing health condition. On the following day, the night nurse documented that during providing morning care to the resident, he/she noted a change to another identified area of the resident #009's body. The physician assessed the resident and referred for another diagnostic procedure of the second identified are. Three days after the home received the result confirming a significant change to the second identified area.

Interview with PCA #201 revealed that on the second identified date, while providing care, the resident complained of discomfort to the first identified area of the body and

was not able to weight bear. The PCA called RPN #202 for assistance and two of them assisted the resident with identified ADL manually, holding the resident under the arms and lifting whole resident's body weight off the floor.

Interview with RPN #202 confirmed that he/she assisted the PCA with identified ADL before supper and later on at bed time, manually by grabbing the resident under arms. The RPN confirmed that they should have used an appropriate assisting equipment as the resident was not able to weight bear.

Interview with the NM #146 revealed that the staff was expected to assess the resident's weight bearing ability prior to each ADL and make sure they transfer the resident safely and anticipate use of an appropriate assisting equipment. [s. 36.]

3. Review of CI report revealed on an identified date resident #031 and his/her family member reported an alleged staff to resident abuse to an Acting Nurse Manager.

Review of resident #031’s MDS assessment and plan of care revealed the resident had an identified health condition. The plan of care indicated the resident requires two-person assist using an assisting device for one of the ADLs.

Review of the home’s investigation records indicated on an identified date, in the morning, PCA #188 had assist the resident with an identified ADL using assisting device on his/her own.

Interview with PCA #188 indicated on an identified date during the morning care, he/she assisted resident #031 with the ADL alone using the assisting device. The staff member did it because there was no staff available for assisting with ADLs at that time. The staff member indicated he/she was aware that the safe ADLs techniques required two staff members doing the intervention together.

Interview with NM #159 indicated the safe ADLs techniques for using an assisting device include one staff member operating the device and another staff member assisting to make sure it is safe. NM #159 confirmed that on the identified date, PCA #188 had assisted resident #031 using an assisting device his/her own, and it was an unsafe technique when assisting the resident. [s. 36.]

4. A CI report was received by the Director on an identified date, related to an incident that caused an injury to the resident which resulted in a significant change in the resident

#007's health status.

Review of CI revealed that on an identified date, PCA was pushing resident #007's assisting device in the hallway to the washroom, when suddenly the resident change the position and had an incident. A physician assessment identified changed condition of resident #007's identified area of the body, and a diagnostic procedure conducted on a specified date confirmed significant change of the resident's identified area of the body. The resident was sent for further assessment and treatment and returned to the home on an identified date.

Review of resident #007's written plan of care revealed that the resident was not able to participate in an identified ADL so the staff was to assist the resident with an assisting device from his/her room to the dining room and back for each meal.

Review of the post incident huddle completed on an identified date indicated that the root causes for the incident, among others was an improper intervention method. The resident was referred to physiotherapist (PT), occupational therapist (OT), and physician. Recommended preventative measures were staff to ensure proper fitted device.

Interview with resident #007 revealed that when the PCA wheeled the resident from the dining room to the toilet on resident's request, the assisting device did not have a supporting aid applied on. The PCA rushed and stopped abruptly and the resident had incident.

Interview with PCA #203 revealed that he/she was looking after the resident on an identified date, but he/she could not recall if he/she applied the supporting aid that morning when he/she assisted the resident with the ADL, neither if the aid was on when he/she wheeled the resident from the dining room to the toilet. However the PCA confirmed that while he/she wheeled the resident towards the toilet, on request of the resident to turn to the closest toilet, the PCA made a sudden turn and the resident flipped forward and sustained incident.

Interview with the OT and PT confirmed that if the supporting aid was in place the resident would be able to support his/her weight when abruptly stopped and would prevent the resident from incident.

Interview with NM #120 confirmed that the staff are expected to make sure before conducting an assistance to the resident with ADLs, that the supporting aid be checked

for safety. The staff are expected to apply the supporting aids when assisting resident with ADLs.

The scope of this non-compliance is pattern as four residents were affected. The severity is actual harm as residents #004, #007 and #009 sustained an injury. The home has no previous noncompliance related to s. 36. Due to the scope and severity of this non-compliance, a compliance order is warranted. [s. 36.] (600)

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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:

s. 6. (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 fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Substitute Decision Maker (SDM) was provided the opportunity to participate fully in the development and implementation of the plan of care.

Review of a CI revealed that resident #004, had an incident while PCA #138 was assisting the resident with ADLs and two days later the resident was diagnosed with significant change in the condition of an identified area of the body. The resident was diagnosed with significant change after the SDM came in to visit the resident and found out from the resident that he/she had an incident and was complaining of discomfort to the identified areas of the body.

Review of resident #004's progress note on an identified date revealed that PCA #138 reported to RPN #139, that while providing care to resident #004 he/she tried to assist the resident with an ADL. Suddenly the resident refused to participate in the process so the PSA assisted to resident to change the position from standing up to sitting to the

floor. The RPN had not identified any injury at that time and he/she decided to close monitor the resident. Further review of the resident's progress notes failed to indicate that the RPN notified the SDM and provided him/her the opportunity to participate in further plan of care to resident #004, after this incident.

Interview with RPN #139 confirmed that he/she did not notify the SDM about the incident and did not provide opportunity to participate in the plan of care.

The home investigation indicated that the RPN had not notified the family when the incident happened.

Interview with the NM #119 confirmed that the staff had not notified the SDM about the incident although the staff is expected to notify the family when there is an incident or a change in resident's condition. [s. 6. (5)]

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

Review of the CI revealed that on an identified date resident #006 was having an acute change in his/her health condition in the corridor outside his/her room after the staff had provided morning care. The PCA observed the resident kneeling towards his/her right side and he/she assisted him/her to the couch. In a few minutes the resident had another episode of changes witnessed by staff. RN #171 assessed the resident, contacted NM #146 who sent resident #006 for further assessment. Resident was diagnosed with significant change of an identified area of the body.

Review of resident #006's chart revealed that on an identified date the resident had series of acute change in the condition and between the first and the second episode the resident had an incident. The resident was sent for further assessment. The resident was diagnoses of significant change of the condition.

Review of resident #006's written plan of care last updated on a specified date revealed that the resident was admitted with identified medical condition, had been identified to be at high risk for incidents and among other intervention to prevent incidents was to have identified protecting aid applied at all the time to prevent an injury.

Observation conducted four days during the inspection, revealed that resident #006 was not wearing the protecting aids.

Interview with RN #129 and RPN # 128 confirmed that resident #006's did not have the protective equipment on the identified dates. However, the interviewed staff was not able to confirm if the resident had a protecting aids on the identified date when the incident happened.

Interview with PCA #166 revealed that he/she was aware of the resident's needs to have the preventing aids on at all times however one of the aids was not on and the other was not always available to be applied to the resident.

Interview with NM #146 confirmed that the home expects the PCA to follow the direction of the plan of care, and to make sure the resident has the protecting aid applied to minimize injury in case of incident. [s. 6. (7)]

3. Review of the CI revealed that resident #004, had an incident while PCA #138 was assisting the resident with ADL and two days later the resident had significant change in the condition of an identified areas of the body.

Review of resident #004's progress note from an identified date revealed that Personal Care Aid (PCA) #138 reported to Registered Practical Nurse (RPN) #139, that while providing care to resident #004, tried to assist the resident in one of the activities of daily living (ADL), the resident suddenly refused to participate in the process. The PCA changed the resident's position from standing up to sitting on the floor. The RPN had not identified any injury at that time and he/she decided to closely monitor the resident. Further review of the resident's progress notes revealed that on the following day, the substitute decision maker (SDM) visited the resident and the resident told him/her that he/she had an incident the previous day and had a discomfort to his/her identified body part. The SDM reported to the RPN who called the physician and he/she ordered a diagnostic procedure. The procedure was completed the same day, however on the following day the resident #004 was called again for further assessment and treatments as the diagnostic procedure had identified injury of the resident’s identified body part.

Review of resident #004's minimum data set (MDS) assessment from an identified date and the written plan of care last updated on a specified date indicated the resident needed extensive, weight bearing assistance by two staff with an identified ADL..

Interview with the PCA #138 revealed that on the identified date, while assisting resident #004 with one of the ADLs, the resident suddenly stood up on his/her feet and grabbed

the bedside rail with a left hand and the bedside table with a right hand. Further, the PCA confirmed that when the resident stood up holding on to the bedside rail and the night stand the PCA insisted the resident to go back to bed, but the resident refused. The PCA stated that somehow he/she managed to change the resident's from standing up to sitting on the floor and went to seek assistance. The PCA confirmed that he/she should have call for assistance by second staff prior he/she transferred the resident alone to the floor.

Interview with NM #119 confirmed that the staff is expected to follow up the direction given in the written plan of care of resident #004. She confirmed that PCA #138 should call the second staff for assistance prior transferring the resident to the floor. [s. 6. (7)]

4. Review of CI report revealed on an identified date resident #031 and his/her family member reported an alleged staff to resident abuse to an Acting Nurse Manager.

Review of resident #031's MDS assessment and plan of care revealed the resident had identified health condition. The plan of care indicated after the about mentioned incident, the assistance to the resident's identified ADLs had been changed from one-person assist to two-person assist.

Review of nursing and personal care record on an identified date, indicated that the identified ADLs for resident #031 were provided with one-person assistance on the day shift.

Interview with PCA #188 indicated that some other staff members may require two-person assistance for an identified ADL, but he/she can perform it by his/her own. The staff member further indicated that it was short-staffed on the specified date, and the resident's care cannot be completed on time if it was done by two-person assist. The staff member confirmed that he/she had assisted with identified ADL and provided care to resident #031 his/her own on that day.

Interview with RPN #189 indicated resident #031 requires two-person assistance for bed mobility because of the resident's physical impairment and his/her weight. One person should support the resident and another person should move the resident and provide the care. The staff member further indicated due to the resident's risk for change in an identified condition, two-person assist for a specific ADL including the mouth care is necessary for safety.

Interview with NM #159 indicated that resident #031's identified ADLs should be performed by two-person assist and it was implemented since the above mentioned incident last year. NM #159 confirmed that the resident's identified ADLs were not provided to the resident as specified in the plan of care when one-person staff assistance was given this year. [s. 6. (7)]

5. The licensee shall ensure that the staff and others who provide direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

This inspection was initiated in response to a CI report submitted by the home related to resident #030 who alleged was rough handled care by staff. Review of the care plan binder on two separate days revealed that the resident's ADL activities care plan was not in the care plan binder.

Interview with PCA #177 and RPNs #178 and #205 revealed that resident #030's ADL written plan of care was not in the binder. Interviews with RPN #178 and NM #159 revealed that PCAs do not have access to plan of care on the computer, and registered staff have to print the written plan of care and put it in the care plan binder for PCAs to access.

Interview with NM #159 confirmed that it was the home's expectation for the written plan of care to be printed and placed the binder. [s. 6. (8)]

6. The licensee has failed to ensure that when the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, have different approaches been considered in the revision of the plan of care

Review of the CI report revealed that on an identified date resident #006 was having an active change in a health condition in the corridor outside his/her room after the staff had provided morning care. The PCA observed the resident kneeling towards his/her right side and he/she assisted him/her to the couch. In a few minutes the resident had another episode of changes witnessed by staff. RN #171 assessed the resident, contacted NM #146 who sent the resident for further assessment. Resident was diagnosed with significant change in the condition of an identified area of the body.

Review of resident #006's chart revealed that on an identified date the resident had series of active changes in a health condition and between the first and the second

episode the resident had an incident. The resident was sent for further assessment and diagnosed with significant change in the condition of an identified area of the body .

Review of resident #006's written plan of care last updated on an identified date revealed that the resident was admitted to the home with identified medical condition and needed assistance for daily decision making and physical assistance for ADLs. Resident was identified to be at high risk for incidents. Further review of resident #006's plan of care revealed that from admission in 2016 until end of the year the resident had numbers of incidents with or without injuries. The goal set when planning care for resident #006 was to remain free of incidents and/or potential injury related to incidents through to the next review date. The next review after 92 days revealed that the goal remain the same as well as the review in the following 92 days assessment. The review of the progress notes also revealed that the resident had numerous incidents from the beginning of 2017, until the start of the inspection. The goal remained the same. Among other interventions set for this goal were staff to encourage the resident of use of his/her mobility devices as the resident often ambulated away from his/her device, and to encourage resident #006 to call for assistance. These interventions were same for every review date.

Review of the post incident huddle records completed after the incidents as a clinical tool for post incident assessment revealed that common root causes for incidents were the resident did not ask for assistance, forget to use device, and his/her impaired ability to recall instruction to call for assistance. However the new strategy for the identified goal in all post incident huddle completed for the incident that was reported were staff to remind the resident to call for assistance, remind the resident if need help to ask for help, remind resident do not try to stand up by himself but ask for help, or continue to monitor the resident. Review of the resident plan of care revealed that all those interventions had been in the written plan of care since the admission in 2016.

Interview with the RN #168 confirmed that they had all possible interventions in the written plan of care and they don't revised the plan of care because the interventions set out in the plan of care some times are effective and sometimes had not been effective.

Interview with NM #146 confirmed that the staff is expected to determine root cause for incidents, consider different approaches and revise the plan of care to reflect the changes. The NM confirmed that the staff should not have used the same approaches over and over if they were not effective. [s. 6. (11) (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 that the SDM are provided the opportunity to participate fully in the development and implementation of the plan of care,
to ensure that the care set out in the plan of care is provided to the resident as specified in the plan,
to ensure that staff who provide direct care to a resident are kept aware of the contents of the plan of care,
to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it,
to ensure that the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, have different approaches been considered in the revision of the plan of care, to be implemented voluntarily.

WN #3: 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:

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 O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. O. Reg. 79/10, s. 30 (1) requires that every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the interdisciplinary programs required under section 48 of this Regulation:
- There must be a written description of the program that includes its goals, objectives

and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee is required by the Act or Regulation to have instituted or otherwise put in place was complied with.

Review of the CI report submitted to the MOHLTC on an identified date revealed that resident #005 had an incident on an identified date and sustained change in an identified area of the body. RN #161 did not identify any other injury so the resident was referred to attending physician and to PT. On another identified date the PT assessed the resident who was complaining of discomfort and was guarding the identified area of the body. The PT recommended and the resident was sent for further assessment. On a specified date the resident was diagnosed with significant change of the identified area of his/her body and was sent home with no specific intervention as he/she had already underwent the treatment of his/her different body area previous month.

Review of the home policy number RC-0518-21 published October 1, 2016, under section "C" indicated that the RN or RPN was to initiate close monitoring routine every hour for 24 hours and assess the resident's level of consciousness and potential injury associated with the incident or symptoms of increased intracranial pressure; Complete incident report and detailed progress notes.

Review of the resident's chart failed to reveal that close monitoring routine record and Incident Report had been initiated for the incident on an identified date and no close monitoring routine record was initiated for the incident on another identified date.

RN #161 was terminated from the home and not able to be reached on the provided number for an interview.

Interview with NM #119 revealed that the home had been provided education to the staff about incident prevention policy and they are expected to initiate close monitoring routine

record for every unwitnessed incident or suspected head injury. He/she also confirmed that the staff was to complete an Incident Report and submitted to the physician and DON for review. The NM also confirmed that he/she was aware that the staff had not completed the close monitoring routine record and the Incident Report mentioned above as he/she had spoken to the staff when the home conducted an investigation. [s. 8. (1) (a),s. 8. (1) (b)]

2. A CI report received on an identified date for an incident that caused an injury to a resident for which the resident's health condition changed.

Review of the CI report revealed that on an identified date resident #006 was having an acute change in a health condition in the corridor outside his/her room after the staff had provided morning care. The PCA observed the resident kneeling towards his/her right side and he/she assisted him/her to the couch. In a few minutes the resident had another episode of changes witnessed by staff. RN #171 assessed the resident, contacted NM #146 who sent the resident for further assessment. Resident was diagnosed with significant change in the condition of an identified area of the body.The resident had a fall again after a few days and was transferred to a hospital with worsening health status.

Review of the home policy number RC-0518-21 published October 1, 2016, under section "C" indicated that the RN or RPN was to complete a post incident huddle for every resident who has an incident.

Review of the resident's chart failed to reveal that incident report and post incident huddle had been completed for the incident on the identified date.

Interview with NM #120 revealed that the staff is expected to complete the post incident huddle and incident report and submit to the physician for review as the policy required. [s. 8. (1) (a),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 that the plan, policy, protocol, procedure, strategy or system for Falls Prevention and Management is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential area were locked when they were not being supervised by staff.

This inspection was initiated in response to a CI report submitted to the Director on an identified date for an incident that happened the day before around 2000 hours when resident #001 was found with significant change in his/her condition in a common area. The amended report review revealed that an investigation was conducted and confirmed cause of the change in a condition was an altered body function.

Interview with registered nurse (RN) #103 revealed that on an identified date, resident #001 was found with significant change in his/her condition in a common area. Further the RN confirmed that the door of a non-residential area had been left open for the evening PCA to pick some items for evening care of the residents. The RN also confirmed that the policy of the home requires all the doors to non-residential areas be kept locked.

Interview with an identified staff confirmed that before he/she left on an identified date he/she left the west door unlocked for the evening PCA to pick up the items. The FSW confirmed that the policy required the door of the area to be locked for residents' safety.

Interview with PCA #140 who found the resident and who picked the items from the non-residential area revealed that the identified staff always leave the door unlock for them to have easy access to the area. The PSW confirmed that the policy required the doors to be locked, but they needed access and they did not have a key for the door. He/she also confirmed that he/she did not report to anyone that the door was being left unlocked and they needed but did not have a key for the door.

Interview with NMs on both floors revealed that the practice in the home was that all doors leading to the non-residential area were to be locked and checked that they were locked on each registered staff rounds. [s. 9. (1) 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 all doors leading to non-residential area are locked when they are not being supervised by staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. O. Reg. 79/10, s. 5.

This inspection was initiated in response to a CI report submitted by the home on an identified date related to resident #019 who was sent for a specified assessment, and was also missing from the home for six hours after return from the hospital.

Review of resident #019's progress notes and records revealed that on an identified date, the resident was sent for a specified assessment from the home, related to the resident's voiced concerns.

Review of the nursing report on an identified date for the day shift revealed that the resident was transferred for the assessment and note for staff to see the progress notes.

Review of the progress notes for the identified date revealed that the nurse practitioner had assessed the resident and documented that the resident had expressed concerns and indication of what he/she wants to do so the home had sent him/her for further assessment.

Review of the progress notes on a specified date revealed that the resident had returned from the assessment with an escort who informed the staff member that the resident had returned. When RPN #105 went to assess the resident after half an hour the resident was not found. During the search, resident #021 informed the staff that he/she had observed resident #019 walking towards a store outside the home. Code yellow was activated and police found the resident and brought him/her home around 1730 hours.

Resident #019 declined to be interviewed by the inspector.

Interview with RPN #104 revealed that he/she was at the nursing station and had received the note from the escort. RPN #104 revealed that he/she was aware that the resident went out on the day of the incident, and was aware that the staff were to monitor the resident when the resident returned, and to notify the nurse manager if there were any situations. He/she revealed that the home's process for residents who return from the hospital with an escort, is for registered staff to go and find the resident and to assess the resident. He/she further revealed for residents who had concerns and return from the assessment, the nursing staff would do appropriate monitoring every half an hour, and to check and monitor the resident. RPN #104 further revealed that he/she did not see the resident when he/she saw the escort at the nursing station, and had not gone to meet the resident or notify another staff to see the resident right away. RPN #104 also revealed that there was a lapse in how the staff responded to this incident, and that the staff should take the initiative to monitor the resident.

Interview with RPN #105 revealed that on the day of the incident, when he/she returned from break, RPN #104 told him/her that resident #019 was back from the assessment. RPN #105 revealed that he/she had asked RPN #104 if he/she had done anything for the resident, and RPN #104 replied that he/she was busy.

Interviews with RPN #110 and #199 revealed that if the escort comes to the nursing station to notify staff that the resident is back and the staff did not see the resident, the registered staff were to immediately go to see that the resident was back and to assess the resident.

Interview with NM #103 revealed that when a registered staff member is made aware that a resident has returned from the hospital, and the staff did not see the resident, it was the home's expectation for that registered staff to go to see the resident and begin the assessments for the resident. NM #103 further revealed that for residents who return, the staff would monitor the residents for at least 72 hours, ranging from one-to-one to every 30 minute DOS monitoring to make sure the staff are aware of where the residents are. The NM also revealed that if the staff was busy, he/she was expected to ask a PCA to meet the residents and see that they were physically there. NM #103 confirmed that it was his/her expectation for the staff to meet the resident upon return and start the assessment process. [s. 19. (1)]

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 protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that includes any mood and behaviour patterns, including identified responsive behaviours.

This inspection was initiated in response to CI report indicating that on an identified date resident #013 had experienced change in the health status.

Review of resident #013's progress notes revealed that on an identified date afternoon in the common area the resident exhibited an identified responsive behaviour toward resident #014. The staff told the resident to stop and removed resident #013 away from the other resident. Staff told resident #013 that his/her action was not appropriate. Police was called and the POA notified. When police talked to the resident that he/she is not to exhibit the identified behaviour toward others in the home, resident #013 became upset and after the police left the resident indicated an identified concern. The social worker visited the resident at the same time to provide emotional support. A next date resident #013 had been seen by the specified team member and referred the resident to specialist to be seen for change in a condition.

Review of the Admission assessment record dated in 2015, revealed that resident #013 had been identified to have experienced some change in a condition once or twice a day.

Review of resident #013's plan of care regarding change in a condition revealed that the resident had not been identified to have a specified change in a condition

Interview with the NM confirmed that the plan of care had not been developed based on an interdisciplinary assessment of the resident, that included identified change in a condition and there were no goals nor interventions to reflect the need of resident #013 in assistance with his/her specified change of condition. [s. 26. (3) 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 responsive behaviour plan of care is based on an interdisciplinary assessment of the resident that includes any mood and behaviour patterns, including identified responsive behaviours, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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 has failed to ensure that when the resident has incident, the resident had been assessed and, a post-incident assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for an incident.

This inspection was initiated in response to CI report submitted to the Director on an identified date regarding an injury that resident #006 sustained after he/she had experienced an acute change in the condition and had an incident.

Review of resident #006's chart revealed that on an identified date resident #006 was observed having an acute change in a condition. The resident was transferred for further assessment and was identified to have significant change in his/her health condition.

Review of resident #006's chart also revealed that resident had an incident on another identified date and was transferred for further assessment.

Review of the post incident assessment record failed to reveal that resident was assessed on the identified date after the incident or after the resident returned from the assessment using a clinically appropriate assessment instrument that was specifically designed for incidents.

Interview with NM #120 revealed that the post incident assessment using a clinically appropriate assessment instrument that is specifically designed for incidents was not done because the staff did not considered this as an incident as the resident had an acute change in the health status which was why was sent for further assessment. The NM confirmed that the staff was expected to complete post incident huddle for each incident but the staff was not sure if this was an incident.

2. Review of the CI report revealed that resident #004, had an incident while PCA #138 was assisting with ADLs. Further the CI revealed that no injury had been identified at that time but the next day the resident had complained of discomfort to the SDM so he/she requested the resident to be transferred for further assessment. Resident returned the same day with no confirmation of any injury but the following day, they called the resident to be transferred back as they had identified change in a condition of an identified area of the body.

Review of resident #004's progress note on an identified date revealed that PCA #138 reported to RPN #139, that while providing care to resident #004 suddenly the resident refused to participate in the process. The PCA changed the resident position. The RPN had not identified any injury at that time and he/she decided to closely monitor the resident. Further review of the resident's progress notes revealed that on an identified date the SDM visited the resident and the resident told him/her that he/she had an incident previous day and had a discomfort to his/her identified area of the body. The SDM reported to the RPN who called the physician and he/she ordered diagnostic procedure. Resident #004 returned to the home, however, the resident was to be transferred back as they had identified change in an identified area of the body.

Interview with RPN #139 confirmed that he/she did not do post incident assessment using a clinically appropriate assessment instrument that is specifically designed for that because the PCA told him/her that the resident did not have an incident, but the PCA had assisted the resident on the floor. After asking to define what is an incident definition by the MDS assessment, the RPN confirmed that after the incident he/she should have assessed the resident using the post incident assessment tool that the home is using.

Interview with NM #119 confirmed that the RPN should recall on the definition for an incident and assess the resident using the identified assessment tool, specifically designed for post incident assessments. [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 the resident has fallen, the resident is assessed and, if required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to inform the Director no later than one business day after the occurrence of an incident for which the resident is taken to a hospital.

Review of CI report revealed an incident happened on an identified date when a staff was ambulating a resident in an assisting device and resident sustained an injury.

Review of resident's chart revealed that Diagnostic Imaging test had confirmed significant change in identified area of the body on an identified date. The next day, the resident was transferred for further assessment. However the CI report was submitted on following day.

Interview with the nurse NM #120 confirmed that none of the staff informed the Director after the occurrence of the incident and acknowledgement that it caused an injury to resident #007 that resulted in a significant change in his/her health condition. Further the NM confirmed that the staff had been trained about the reporting of critical incident and they are expected to inform the incident to the Director and if needed, to be amended

after collecting sufficient information. [s. 107. (3)]

2. Review of CI report revealed that resident #004, had an incident on an identified date. The next day the resident was transferred for further assessment The following day the resident was identified to sustained significant change to an identified area of the body. The Director was not informed in one business day after the resident was sent for a treatment with injury after the incident but the CI report was submitted two days later.

Interview with RPN #139 revealed that he/she was not considering resident #004 to have had an incident, that is why he/she did not reported to the Director or the NM.

Interview with NM #119 confirmed that based on the definition for incident the resident had an incident and the RPN would be expected to report to the NM immediately so it would be reported to the Director. [s. 107. (3)]

3. The licensee has failed to ensure that the licensee made a report in writing to the Director of any of the incidents described in r. 107 (1), (3) or (3.1), within 10 days of becoming aware of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

Review of the CI report revealed that on an identified date resident #006 was having an acute change of a condition.

Review of resident #006's progress notes revealed that on an identified date resident #006 was observed having series of acute activities. The resident was sent for further assessment and was identified to have significant change in his/her health condition. Resident #006 returned to the home the following day when the home submitted the CI report.

Review of CI report revealed that incident happened on an identified date however the progress notes revealed that the incident happened two days prior and that resident #006 was on the floor. The CI report from the latest date failed to identify the type of incident, date and time of incident and the events leading up to the incident.

Interview with the NM #146 confirmed that the staff is expected to comply with the MOHLTC regulation regarding CI reporting and to complete the report to the best knowledge about the reporting matter. [s. 107. (4) 1.]

4. The licensee has failed to ensure that the written report included a description of the individuals involved in the incident, including names of any staff members or other persons who were present at or discovered the incident.

Review of CI report revealed that PCA was ambulating resident with an assisting device and had an incident. The CI failed to identify the name of the staff who was present when the resident had an incident.

Interview with the nurse manager (NM) #119 confirmed that the CI report did not include the name of the staff member who was present on the incident, and further he/she acknowledged that he/she should have included the name of the PCA who assisted the resident in the device when the incident happened. [s. 107. (4) 2.]

5. Review of CI report revealed that on an identified date resident #006 was having an acute change in a condition. A few minutes later the resident had another episode. Resident was assessed and sent for further assessment. The resident returned two days after, diagnosed with significant change in the condition. Review of the CI report failed to identify the name of the person who was present or discovered the incident.

Interview with the nurse manager (NM) #120 confirmed that the CI did not include the name of the staff member who was present on the incident, and further he/she acknowledge that he/she should have included the name of the PCA who assisted the resident in the identified device when the incident happened. [s. 107. (4) 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 inform the Director no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital,
to ensure that when the licensee make a report in writing to the Director of any of the incidents described in r. 107 (1), (3) or (3.1), within 10 days of becoming aware of the incident, that includes a description of the incident, including the type of incident,
to ensure that the written report include a description of the individuals involved in the incident, including names of any staff members or other persons who were present at or discovered the incident, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training relating in behaviour management.

This inspection was initiated in response to a CI report submitted by the home on an identified date related to resident #019 who was sent to hospital for further assessment.

Review of the home's Behaviour Management training records revealed that 13 per cent (60 of 460 staff members) of all staff who provided direct care to residents did not complete the training.

Interview with the Assistant Administrator revealed that all staff has the potential to provide direct care for the residents, and it is the home's expectation for all staff who provide direct care to residents to be trained on responsive behaviours and behaviour management. He/she further revealed that the managers were responsible to follow up with the staff regarding their training. The Assistant Administrator confirmed that not all staff who provide direct care to residents received training on responsive behaviours and behaviour management. [s. 76. (7) 3.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

The MOHLTC had received a call on an identified date in regards to a suspected abuse that had happened to resident #050. A review of MOHLTC Incident record revealed that the Acting Nurse Manager called the MOHLTC to report a change of a condition of an identified body part of a resident.

Further review of CI report revealed that no report was made and submitted to the Director by the home.

A review of resident #050's plan of care indicated the resident had some identified medical condition. A review of the resident's progress notes indicated on an identified date RPN #190 noted a change on the resident's identified areas of the body. The resident was unable to explain how it happened. The staff member had completed and filed an incident report. The treatment was applied and the SDM and the physician were notified.

Interview with RPN #190 indicated he/she assessed the resident and the change was on the resident's identified area of the body, but not the change of the other resident's body areas. The staff member indicated he/she did not suspect an abuse had happened at that time.

Interviews with Acting NM #120, NM #159, DON, and the Administrator indicated that NM would be one of the staff members responsible for reporting an abuse to the Director. Interview with NM #120 indicated after reviewing the progress notes and the incident report on an identified date, he/she interviewed the resident and was told an identified allegation. Although it was unclear, the staff member had reasonable ground to suspect an abuse had happened. The staff member called the MOHLTC after-hours number to report the incident.

NM #120 further confirmed that he/she was responsible to submit a CIS report on the next day, but he/she did not. The staff member did not recall why the report was not submitted to the Director as required. [s. 104. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 232. Every licensee of a long-term care home shall ensure that the records of the residents of the home are kept at the home. O. Reg. 79/10, s. 232.

Findings/Faits saillants :

1. The licensee has failed to ensure that the records of the residents of the home are kept at the home.

This inspection was initiated in response to a CI report submitted by the home on an identified date related to an incident for resident #028 related to his/her care that occurred previous day.

Review of the resident's progress notes revealed that for an identified period of time in 2017, there was one entry dated one day and no other entries available in the chart until a partial entry had been documented an identified number of days later which began with "continued."

Interview with RPN #162 revealed that the partial documentation on the identified date was his/her documentation and that the progress note page that he/she had documented on was missing. He/she further revealed that he/she had also documented on previous day on resident #028 and this documentation was part of the missing double-sided progress note. He/she also revealed that three days later when he/she returned to work, he/she was made aware of the missing progress note, and put in a late entry relaying his/her documentation on the previous date, regarding the incident.

Interview with NM #159 confirmed that the progress notes on the aforementioned dates were missing, and that the home was unable to find the missing document for resident #028. [s. 232.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 233. Retention of resident records

Specifically failed to comply with the following:

s. 233. (2) A record kept under subsection (1) must be kept at the home for at least the first year after the resident is discharged from the home. O. Reg. 79/10, s. 233 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the record of every former resident of the home is kept at the home for at least the first year after the resident is discharged.

The MOHLTC had received a call on an identified date in regards to suspected abuse had happened to resident #050. A review of MOHLTC Incident record revealed that the Acting Nurse Manager called the MOHLTC to report a change on an identified body part of a resident.

A review of resident #050's plan of care and the home's records indicated the resident was discharged from the home an identified date. A review of the resident's progress notes indicated on another identified date RPN #190 noted a change on an identified body part of a resident. The resident was unable to explain how it happened. The staff member had completed and filed an incident report. The treatment was applied and the Substituted Decision Maker (SDM) and the physician were notified.

Further review of the resident's incident reports for two months in 2016, revealed no records of the above mentioned incident report.

Interview with RPN #190 indicated he/she assessed the resident and completed the home's incident report paper form for the resident and filed it at that time. Since the resident had been discharged, the clinical records had been archived.

Interview with NM #120 confirmed that the resident was discharged on an identified date and that he/she remembered reading the above mentioned incident report. The NM further confirmed that the incident report should be kept in the resident's archived records in the home, but it was not. [s. 233. (2)]

Issued on this 27th day of June, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GORDANA KRSTEVSKA (600), IVY LAM (646), MATTHEW CHIU (565)
Inspection No. / No de l'inspection :	2017_635600_0008
Log No. / Registre no:	019886-16, 020341-16, 021232-16, 022156-16, 022558-16, 023592-16, 025225-16, 025233-16, 027319-16, 027859-16, 028300-16, 028827-16, 029378-16, 029769-16, 030101-16, 030630-16, 031785-16, 031895-16, 034186-16, 034816-16, 034954-16, 000238-17, 000342-17, 001493-17, 003412-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 15, 2017
Licensee / Titulaire de permis :	City of Toronto 55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6
LTC Home / Foyer de SLD :	CASTLEVIEW WYCHWOOD TOWERS 351 CHRISTIE STREET, TORONTO, ON, M6G-3C3

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Nancy Lew

---

To City of Toronto, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that staff use safe transferring and positioning devices or techniques when assisting residents. The plan shall include but not be limited to the following:
1. All staff to be trained and retrained on:
a) assessment of a resident for safe transferring when the resident experiences a change in status,
b) safe positioning, including the use of devices, and transferring techniques,
2. To develop a schedule to test and monitor nursing staff knowledge and compliance on safe transferring and positioning technique.

This plan is to be submitted via email to inspector Gordana.Krstevska@ontario.ca by June 27, 2017.

Grounds / Motifs :

1. A CI report was received by the Director on an identified date, related to an incident that caused an injury to the resident which resulted in a significant change in the resident #007's health status.

Review of CI revealed that on an identified date, PCA was pushing resident #007's assisting device in the hallway to the washroom, when suddenly the resident change the position and had an incident. A physician assessment identified changed condition of resident #007's identified area of the body, and a diagnostic procedure conducted on a specified date confirmed significant change of the resident's identified area of the body. The resident was sent for further assessment and treatment and returned to the home on an identified date.

Review of resident #007's written plan of care revealed that the resident was not able to participate in an identified ADL so the staff was to assist the resident with an assisting device from his/her room to the dining room and back for each meal.

Review of the post incident huddle completed on an identified date indicated that the root causes for the incident, among others was an improper intervention method. The resident was referred to physiotherapist (PT), occupational therapist (OT), and physician. Recommended preventative measures were staff to ensure proper fitted device.

Interview with resident #007 revealed that when the PCA wheeled the resident from the dining room to the toilet on resident's request, the assisting device did not have a supporting aid applied on. The PCA rushed and stopped abruptly and the resident had incident.

Interview with PCA #203 revealed that he/she was looking after the resident on an identified date, but he/she could not recall if he/she applied the supporting aid that morning when he/she assisted the resident with the ADL, neither if the aid was on when he/she wheeled the resident from the dining room to the toilet. However the PCA confirmed that while he/she wheeled the resident towards the toilet, on request of the resident to turn to the closest toilet, the PCA made a sudden turn and the resident flipped forward and sustained incident.

Interview with the OT and PT confirmed that if the supporting aid was in place the resident would be able to support his/her weight when abruptly stopped and would prevent the resident from incident.

Interview with NM #120 confirmed that the staff are expected to make sure before conducting an assistance to the resident with ADLs, that the supporting aid be checked for safety. The staff are expected to apply the supporting aids when assisting resident with ADLs.

The scope of this non-compliance is pattern as four residents were affected. The severity is actual harm as residents #004, #007 and #009 sustained an injury. The home has no previous noncompliance related to s. 36. Due to the scope and severity of this non-compliance, a compliance order is warranted.

The scope of this non-compliance is pattern as four residents were affected. The

severity is actual harm as residents #004, #007 and #009 sustained an injury. The home has no previous noncompliance related to s. 36. Due to the scope and severity of this non-compliance, a compliance order is warranted. (600)

2. Review of CI report revealed on an identified date resident #031 and his/her family member reported an alleged staff to resident abuse to an Acting Nurse Manager.

Review of resident #031's MDS assessment and plan of care revealed the resident had an identified health condition. The plan of care indicated the resident required two-person assist using an assisting device for one of the ADLs.

Review of the home's investigation records indicated on an identified date, in the morning, PCA #188 had assist the resident with an identified ADL using an assisting device on his/her own.

Interview with PCA #188 indicated on an identified date during care, he/she assisted resident #031 with the ADL alone using the assisting device. The staff member did it because there was no staff available for assisting with ADLs at that time. The staff member indicated he/she was aware that the safe ADLs techniques required two staff members doing the intervention together.

Interview with NM #159 indicated the safe ADLs techniques for using an assisting device include one staff member operating the device and another staff member assisting to make sure it is safe. NM #159 confirmed that on the identified date, PCA #188 had assisted resident #031 using an assisting device his/her own, and it was an unsafe technique when assisting the resident. (565)

3. A CI report was received by the Director on an identified date related to an incident that caused an injury to the resident which resulted in a significant change in resident #009's health condition.

Review of CI report revealed series of events happened to resident #009:
On an identified date – change in a condition of an identified area of resident's body;
The following day - a physician assessed the resident regarding the changes in the identified area of the body and ordered a diagnostic procedure;
The next day, staff noted significant change of another identified area of the

body; the resident was assessed by the physician and ordered another diagnostic procedure;
Three days after the procedure, the home received report from the diagnostic department regarding some changes of the first identified area of the body and significant changes to the second identified area of the body.

Review of resident #009's chart revealed that resident was admitted to the home with an identified health condition. The resident was identified to need assistance by staff to make decisions for daily living and physical assistance by staff for all ADLs.

Review of the resident's progress notes on an identified date revealed that the evening nurse noted resident #009 to have changed condition to an identified area of the body. The resident also had been complaining of discomfort to the identified area during care provided. On the next day the physician assessed the resident, prescribed a treatment and referred the resident for a diagnostic procedure considering the existing health condition. On the following day, the night nurse documented that during providing morning care to the resident, he/she noted a change to another identified area of the resident #009's body. The physician assessed the resident and referred for another diagnostic procedure of the second identified area. Three days after the home received the result confirming a significant change to the second identified area.

Interview with PCA #201 revealed that on the second identified date, while providing care, the resident complained of discomfort to the first identified area of the body and was not able to weight bear. The PCA called RPN #202 for assistance and two of them assisted the resident with identified ADL manually, holding the resident under the arms and lifting whole resident's body weight off the floor.

Interview with RPN #202 confirmed that he/she assisted the PCA with identified ADL before supper and later on at bed time, manually by grabbing the resident under arms. The RPN confirmed that they should have used an appropriate assisting equipment as the resident was not able to weight bear.

Interview with the NM #146 revealed that the staff was expected to assess the resident's weight bearing ability prior to each ADL and make sure they transfer the resident safely and anticipate use of an appropriate assisting equipment.
(600)

4. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A critical incident (CI) report was received by the Director on an identified date related to an incident that resulted in a significant change in the resident's condition.

Review of resident #004's progress note from an identified date revealed that Personal Care Aid (PCA) #138 reported to Registered Practical Nurse (RPN) #139, that while providing care to resident #004, tried to assist the resident in one of the activities of daily living (ADL), the resident suddenly refused to participate in the process. The PCA assisted to change the resident's position from standing up to sitting on the floor. The RPN had not identified any injury at that time and he/she decided to closely monitor the resident. Further review of the resident's progress notes revealed that on the following day, the substitute decision maker (SDM) visited the resident and the resident told him/her that he/she had an incident the previous day and had a discomfort to his/her identified area of the body. The SDM reported to the RPN who called the physician and he/she ordered a diagnostic procedure. The procedure was completed the same day, however on the following day the resident #004 was called again for further assessment and treatments as the diagnostic procedure had identified injury of the resident's identified area of the body.

Review of resident #004's minimum data set (MDS) assessment from an identified date and the written plan of care last updated on a specified date indicated the resident needed extensive, weight bearing assistance by two staff with an identified ADL.

Interview with PCA #138 revealed that on the identified date, while assisting resident #004 with one of the ADLs, the resident suddenly stood up on his/her feet and grabbed the bedside rail with a left hand and the bedside table with a right hand. Further, the PCA confirmed that when the resident stood up holding on to the bedside rail and the night stand the PCA insisted the resident to go back to bed, but the resident refused. The PCA stated that somehow he/she managed to change the position of the resident from standing up to sitting on the floor and went to seek assistance.

Interview with Nurse Manager (NM) #119 confirmed that the staff is expected to

assess the resident's condition and ability for transfer and include safe techniques while transferring the residents.
(600)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 11, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 15th day of June, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Gordana Krstevska

Service Area Office /
Bureau régional de services : Toronto Service Area Office