Ontario

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 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 29, 2019	2019_630589_0026	020032-19	Complaint

Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 365 Bloor Street East, 15th Floor TORONTO ON M4W 3L4

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

JOANNE ZAHUR (589)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 14, 15, 19, 20, 21, & 22, 2019. November 27, 2019, off-site.

The following inspection was conducted:
Log #020032-19 related to alleged neglect of oral care and wound care and missing clothing/personal items.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Clinical Nurse Managers (C-NM), Nurse Manager of Operations (NM-O), Registered staff (RN/RPN), Personal Support Workers (PSW), Physician, Registered Dietitian (RD), Acting Manager of Building Services (A-BS), former Administrator, and family member.

During the course of this inspection medical records were reviewed, and resident to staff interactions were observed.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 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	Légende 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #001 so that their assessments were integrated, consistent with and complement each other.

The Director received a complaint with several areas of concern, with one specifically about alleged neglect related to care.

A review of the hospital discharge summary from a hospitalization indicated the attending physician documented that a contributing factor to resident #001's underlying health status was related to a specific care need.

During an interview, staff #103 stated that when a resident returns from hospital, the registered staff receiving the resident is to review the discharge summary and communicate any relevant information from the hospitalization to the nurse manager on duty, assess the need to review and update the care plan as required. In this case, when resident #001 was re-admitted to the long term care home (LTCH), the registered staff did not communicate the hospital physician's summary note.

Staff #103 acknowledged that the registered staff had failed to collaborate with the nurse manager regarding relevant information about resident #001. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the provision of care set out in the plan of care for resident #001 was documented.

A review of resident #001's health record indicated they had been diagnosed with an underlying health condition by their LTCH primary physician. The primary physician had ordered that specific treatments be administered to treat this condition at specific times throughout the day.

A review of the treatment administration records (TARs) from an identified period of time in 2019, indicated that one of resident #001's specific treatments had not been documented as provided six times at a specified time, and the second treatment had not been documented as provided 17 times on specifically ordered times during the same identified period.

During a conversation with staff #103 they acknowledged that registered staff had not documented the provision of care set out in the plan of care for resident #001. [s. 6. (9) 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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee has failed to ensure that weekly wound assessments were completed for resident #001 when exhibiting altered skin integrity, that included pressure ulcers, by a member of the registered nursing staff.

The Director received a complaint alleging neglect related to altered skin integrity.

A review of resident #001's health record indicated they had three areas of altered skin integrity. Further record review indicated dressing orders in place which provided specific directions to the registered staff to follow, assessments by an enterostomal (ET) nurse, with the most recent being completed on an identified date in September 2019, and assessments completed by the long term care home's (LTCH) registered dietitian (RD) related to nutritional interventions specific to resident #001's altered skin integrity care.

A review of the treatment administration records (TARs) for a three month period in 2019, indicated that weekly wound assessments to resident #001 had not been consistently completed. A further review indicated that weekly wound assessments had not been completed as follows:
-first area on four occasions,
-second area on three occasions, and
-third area on four occasions.

During a conversation, staff #101 acknowledged that weekly wound assessments had been missed by members of the registered nursing staff in the home. [s. 50. (2) (b) (iv)]

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 weekly wound assessments are completed for the resident when exhibiting altered skin integrity, that includes pressure ulcers, by a member of the registered nursing staff, to be implemented voluntarily.

Issued on this 4th day of December, 2019

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

Original report signed by the inspector.