



**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 sous la  
Loi de 2007 sur les foyers de  
soins de longue durée**

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Division de la responsabilisation et de la  
performance du système de santé  
Direction de l'amélioration de la  
performance et de la conformité

**Public Copy/Copie du public**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Jan 25, 2013	2013_108110_0001	T-00560-12	Complaint

**Licensee/Titulaire de permis**

TORONTO LONG-TERM CARE HOMES AND SERVICES  
55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6

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

CASTLEVIEW WYCHWOOD TOWERS  
351 CHRISTIE STREET, TORONTO, ON, M6G-3C3

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

DIANE BROWN (110)

**Inspection Summary/Résumé de l'inspection**



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

This inspection was conducted on the following date(s): January 14th, 15th, 16th and 21st, 2013

During the course of the inspection, the inspector(s) spoke with Acting Administrator, Director of Care (DOC), nurse manager, Registered staff, Personal Care Aides (PCA's), staff educator, social worker, residents.

During the course of the inspection, the inspector(s) Observed staff resident interaction; resident health record review relevant to inspection; home policies and staff education relevant to inspection.

This inspection related to LOG # T-00560-12 and T-2058-12

The following Inspection Protocols were used during this inspection:  
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

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**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

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Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités



Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)

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. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**

**1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee did not ensure that the following rights of residents are fully respected and promoted.

Resident #001 was not treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the residents' dignity.

An interview was conducted with resident #001 along with a social worker staff.

Resident #001 repeatedly gestured and pointed to yes when asked if they were afraid of the way they were treated by staff. The resident was able to communicate that he was afraid at night of one part time staff member. [s. 3. (1) 1.]



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***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 resident #001 is treated with courtesy and respect., to be implemented voluntarily.***

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**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. (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).**

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**Findings/Faits saillants :**

1. The licensee did not ensure the care set out in the plan of care was provided to resident #001 as specified in the plan.

Resident #001 was involved in a resident to staff altercation resulting in a resident injury.

Resident #001's plan of care for "Behaviour problem" (in place prior to the altercation) included the strategy to "provide a consistent caregiver".

For the period of 21 days leading up to the altercation the resident was assigned 16 different staff members to provide care. Ten (10) different staff member on days and 6 different staff members on evenings during this time period.

An interview with the unit's full time RPN revealed that resident #001 does better with a consistent staff member. [s. 6. (7)]

***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 care set out in resident #001's plan of care is provided as specified in the residents plan., to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training**



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**Specifically failed to comply with the following:**

**s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:**

- 1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).**
- 2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).**
- 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).**
- 4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).**
- 5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).**
- 6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).**
- 7. Fire prevention and safety. 2007, c. 8, s. 76. (2).**
- 8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).**
- 9. Infection prevention and control. 2007, c. 8, s. 76. (2).**
- 10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).**
- 11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).**

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**Findings/Faits saillants :**

1. Staff, from the nursing department, were interviewed during the course of this inspection conducted on January 14th, 15th and 16th, 2013. Staff interviews revealed that staff were unaware of mandatory reporting under Section 24 of the Act and some staff could not recall receiving training. [s. 76. (2) 4.]

***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 no staff performs their responsibilities before receiving training in the areas outlined in the legislation., to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents**



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**Specifically failed to comply with the following:**

**s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).**

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**Findings/Faits saillants :**

1. The license failed to ensure that the resident's substitute decision-maker (SDM) was notified of the results of the alleged abuse or neglect investigation immediately upon completion.

An interview with resident #001's SDM revealed that he was contacted at the onset of an incident of alleged abuse but not notified again after the investigation was completed.

An interview with the Director of Care revealed that the investigation concluded around October 9th 2012 but that the resident's SDM was not notified. [s. 97. (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 resident #001's substitute decision-maker is notified of the results of the investigation immediately upon the completion of the investigation., to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff**

**Specifically failed to comply with the following:**

**s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:**

**1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).**

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**Findings/Faits saillants :**



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1. The licensee did not ensure that all staff who provide direct care to residents receive annual training in all areas required under subsection 76(7) of the Act. Staff members #001 and #002 provide direct care to residents. Staff member #001 involved in a resident to staff altercation did not receive annual training in 2012 in all the areas required under subsection 76(7) of the Act- specifically abuse recognition and prevention and behaviour management. Staff member #002 a witness to a resident to staff altercation did not receive annual training in 2012 in all the areas required under subsection 76(7) of the Act- specifically behaviour management. An interview with the homes' staff educator confirmed that the identified staff missed being trained in the above noted areas. A review of 2012 annual training for 5 additional staff members, who provide direct care, revealed that 2 out of 5 did not receive annual training in 2012 in all the areas required under subsection 76(7) of the Act- specifically abuse recognition and prevention. [s. 221. (2) 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 all staff who provide direct care to residents receive annual training in all areas required under subsection 76(7) of the Act., to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance**



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**Specifically failed to comply with the following:**

**s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,**

**(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).**

**(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).**

**(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).**

**(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).**

**(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).**

**(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).**

**(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).**

**(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).**

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**Findings/Faits saillants :**

1. The homes policy Zero tolerance for Abuse and Neglect RC-0305-00 last reviewed November 1st, 2011 does not contain an explanation of the duty under section 24 of the Act to make mandatory reports. [s. 20. (2)]

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Issued on this 25th day of January, 2013

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

*Dalene Brown*