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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 27, 2014	2013_109153_0027	T-640-13	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

LYNN PARSONS (153), LALEH NEWELL (147)

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, 18, 19 20, 21, 22, 25, 26, 27, 28, December 2, 3, 4, 13, 2013 and January 14, 15, 2014.

During the course of the inspection, the inspector(s) spoke with Administrator, Assistant Administrator, Acting Director of Nursing (DON), Medical Director, Coroner, Attending Physician, Psychiatrist, Nurse Manager, Behaviour Support Nurse, Counsellor, Police, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Aides (PCA), Manager of Building Services, Social Worker, Housekeepers, Dietary Aide, Recreation Assistant, Resident Assessment Instrument Co-ordinator (RAI), Support Assistant, Resident and Family.

During the course of the inspection, the inspector(s) reviewed resident clinical records,staff schedules, home internal investigation, staff training records,

home policies and procedures related to Prevention of Abuse, Care of Body After Death, Interpreter List, Communication Methods, Vital Signs, Responsive Behaviours, Altercations and Potentially Harmful Interactions Between and Among Residents, Code White, Residents' Bill of Rights, Police Reference Checks, Significant Change in Status and Shift Duties and Responsibilities for Nursing Staff.

Summary of Facts:
1. Resident #1 was admitted to Castleview Wychwood Towers in January 2013.

Resident #2 was admitted to Castleview Wychwood Towers in August 2012. Resident #1 and Resident #2 were roommates.

2. Upon admission, Resident #1 required extensive assistance managing his activities of daily living. The resident was ambulatory with the use of a cane. Interviews with staff revealed that Resident #1 spoke and understood a language other than English (His Language) but experienced great difficulty in understanding or conversing in the English language. At times he would attempt to push staff away and state "no, no" when he refused to have care provided. During periods of increased confusion, agitation and wandering Resident #1 would verbalize his anxieties in His Language. During the period that Resident #1 was in the home, no staff member assigned to work on the unit spoke or understood His Language.

Resident #2 required extensive assistance with activities of daily living. He required a wheel chair for locomotion and staff assistance to transport him to and from areas in the home.

3. Between January 2013 and February 2013 Resident #1 demonstrated periods of agitation and confusion. He was assessed by the physiotherapist who recommended a walker be obtained for mobility. Resident #1 was noted to be awake on several night shifts pacing up and down the hallway. Staff attempted to redirect him without success. The resident was speaking His Language and staff were unable to understand what he was saying.

4. At the end of February 2013 Resident #1 was restless and agitated on days and nights, wandering in and out of residents' rooms throughout the unit. He would attempt to strike out at staff when they tried to redirect him and would

refuse medications at times. He was assessed by the physician and an adjustment was made to his medication regime.

5. On one occasion another male resident reported that Resident #1 had entered his room and hit him with a bed controller. There was no injury and staff redirected Resident #1 out of the room. Resident #1 continued to roam throughout the unit and he was difficult to redirect due to the language barrier. A referral was completed for a psychiatric assessment.

6. The psychiatrist attempted to assess Resident #1 due to increased confusion, restlessness, agitation and a recent incident of physical aggression however the resident was not able to be roused and only a medication review could be completed of the current medication regime. The psychiatrist recommended the addition of other medication changes. Resident #1's spouse met with the psychiatrist and provided some information to the psychiatrist about the resident's state of mind.

7. Between March 2013 and August 2013 Resident #1's behaviours fluctuated. He had episodes of sad mood, crying, agitation and restlessness. These episodes varied in their frequency and intensity during this period. Medication adjustments were made to manage these behaviours. There continued to be a language barrier as staff did not understand Resident #1 when he spoke His Language. The psychiatrist assessed Resident #1 once during this period and Resident #1's spouse provided some interpretation.

8. Near the end of August 2013 Resident #1 shared with his family, speaking in His Language, that he did not feel safe. He told his family that people were being killed at the home and he feared he would be next. The family attempted to reassure the resident he was safe and reported this to a registered staff member who also attempted to reassure Resident #1 of his safety. The attending physician was notified who then made changes to the resident's medications.

9. Resident #1's family continued to report to staff that Resident #1 was paranoid and experiencing hallucinations. Staff did not know he was experiencing paranoia and hallucinations other than through family members. The resident only spoke His Language and staff could not understand what he was saying.

10. Around the middle of September 2013 the psychiatrist assessed Resident #1

and found him to be paranoid, and experiencing hallucinations and a sense of fearfulness. During the course of this assessment, the psychiatrist attempted to access an interpreter through a telephone line, but there were technical issues. They were able to connect with two interpreters who advised the psychiatrist that the resident was incoherent and not responding to the questions. The recommendation was to reinstate the previously ordered medication and discontinue the current medication gradually over a few days. The psychiatrist documented on the follow-up report provided to the home that it would be ideal to have an interpreter available for the next visit.

11. Over the next two weeks staff identified there was a decrease in the number of episodes of agitation experienced by Resident #1.

12. The psychiatrist visited Resident #1 near the end of September 2013. The resident was asleep and could not be roused. Staff reported to the psychiatrist some improvement in the level of agitation, although Resident #1 continued to have periods of time when he is suspicious but appeared less scared. The psychiatrist noted Resident #1's delusions and hallucinations worsened when the previous medication was discontinued.

13. From the end of September 2013 to November 7, 2013 Resident #1's behaviours were more controlled. He occasionally experienced episodes of crying, agitation and refusal to come for meals.
On November 5, 2013 the Behavioural Support Team indicated Resident #1's behavioural issues seem controlled in the past weeks except for occasional episodes of crying, agitation and refusing medications.

14. On November 7, 2013 the psychiatrist assessed Resident #1 and found that his behavioural issues were well controlled and there were no acute safety concerns. No interpreter was present for this assessment.
Resident #1 was calmer, less paranoid and less distressed. The psychiatrist recommended medication adjustments.

15. During the night shift commencing at 2300 hours on November 7, 2013 and ending at 0700 hours on November 8, 2013, Resident #1 was resistive and unco-operative when staff attempted to provide care.

16. During the day on November 8, 2013 Resident #1 was weepy when

approached and refused care when offered by staff. Another staff member tried to encourage Resident #1 to accept care but the resident refused and attempted to push the staff member away. Staff left the resident in his room. During the evening shift Resident #1 was weepy, walking back and forth in his room and did not want to come to the dining room for dinner. Two staff brought Resident #1 to the dining room and he ate a full meal. He took his medications when administered.

**17. The night shift began at 2300 hours on November 8, 2013 and ended at 0700 hours on November 9, 2013. Resident #1 slept most of the night.
At 0530 hours two Night Staff (#S113 and #S119) entered the identified resident room to provide care to Resident #1 and Resident #2. One of the Night Staff (#S113) went to Resident #1's bedside, turned the lights on and said good morning which caused the resident to wake up. Resident #1 sat up on the edge of the bed muttering in His Language which the staff member could not comprehend. The Night Staff (#S113) was recently hired by the home and had never provided care to Resident #1 and Resident #1 had never met this staff member until that moment. The Night Staff (#S113) introduced self and attempted to explain in English the care that was going to be provided. When the Night Staff (#S113) attempted to provide care to Resident #1 he began waving his hands/arms as if to push the staff member away and said, "No, No".
The other Night Staff (#S119) who was providing care to Resident #2 directed the Night Staff (#S113) to leave Resident #1 alone if he was refusing to have care provided and indicated he had also refused to have care provided on the previous night shift. Both Night Staff (#S113 and #S119) left the room and continued with the completion of the early morning round.**

18. On November 9, 2013 at approximately 0645 hours a Day Staff (#S131) heard audible sounds coming from Resident #1 and Resident #2's room on the identified C unit. Upon entering the room the Day Staff (#S131) observed Resident #2 lying in bed calling out. The Day Staff (#S131) spoke to Resident #2 asking if he was hungry and provided reassurance indicating the staff member would be back later to get him ready for breakfast. The Day Staff (#S131) observed Resident #1 lying quietly on his bed. The Day Staff (#S131) left the room and proceeded to the change of shift report which commenced at 0700 hours.

19. All staff scheduled to work the day shift on the unit on November 9, 2013

attended the shift report from 0700 to 0730 hours. The report took longer on this specific day because staff needed to have their resident assignments altered due to the shortage of 1 Day Shift position that could not be replaced. As a result the Day Staff (#S122) assisted with medication administration and the other Day Staff assumed additional resident care assignments.
During the change of shift report no staff were assigned to or were present in the unit where Resident #1 and Resident #2 resided.

Following the change of shift report staff proceeded to their assigned areas to commence morning care to their specific residents prior to breakfast.

At approximately 0815 hours the Day Staff (#S131)assigned to provide care to Resident #1 and Resident #2 attempted to enter their room on the identified unit. The Day Staff (#S131) found the door closed. When the Day Staff (#S131) tried to open the door it was found to be blocked. The Day Staff (#S131) was able to open the door enough to see Resident #1 standing behind the closed door covered in blood from his fingers to his elbows. Resident #1 was muttering in His Language. The Day Staff (#S131) could not understand what he was saying because the Day Staff (#S131) did not understand His Language. When the Day Staff (#S131) looked towards Resident #2, he was noted to be lying in bed with the sheets pulled up to his chest, motionless with blood on his face, head, pillow, side rails and walls. The Day Staff (#S131) did not approach Resident #2 but began calling for help.
A Day Staff (#S100) responded to the call for help and proceeded to the identified resident room. Multiple staff members were involved from this point forward.
The paramedics arrived at approximately 0830 hours. They could not resuscitate Resident #2.
The Coroner was contacted and arrived on site.
Resident #1 was arrested and removed from the home.

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

1. The Licensee failed to ensure strategies are implemented to meet the needs of residents with compromised communication including residents who cannot communicate in the language or languages used in the home.

This finding of non-compliance is supported by the facts set out in the Summary of

Facts in the Inspection Summary and the following:

Resident #1 was identified with compromised communication due to a language barrier.
Interviews with staff revealed that Resident #1 spoke and understood a language other than English but experienced great difficulty in understanding or conversing in the English language. At times he would attempt to push staff away and state "No, No" when he refused to have care provided. Otherwise he did not speak English. He would try to communicate with staff using hand gestures.
During periods of increased confusion, sadness, agitation and/or wandering, Resident #1 would verbalize his anxieties by muttering in his spoken language, which the staff could not understand.

Between late August and the middle of September 2013 when Resident #1 was experiencing increased anxiousness and agitation, staff could not understand Resident #1 because he only spoke a language other than English and none of the staff understood him. No steps were taken to communicate with Resident #1 so that they could assess his state of mind. It was only when the resident's family who communicated with the resident in his spoken language reported to staff that the resident thought people were being killed at the home and he was not safe, that staff understood why he was exhibiting this anxiety at which time staff notified the physician who interceded. Between the end of August 2013 and the middle of September 2013 when the psychiatrist assessed Resident #1, staff, including management, did not take any other steps or implement any other strategies to communicate with the resident to be able to assess his state of mind or meet his needs. The only information about the resident's state of mind came from the resident's family. Resident #1's plan of care last revised in October 2013 does not include any implemented strategies to meet his needs related to his language spoken and understood other than using non-verbal communication techniques including the use of short, direct phrases and maintain eye contact.

The home failed to develop and implement strategies to meet Resident #1's need for communication in his spoken language during these periods of increased confusion and agitation when staff were unable to determine the cause of the change in behaviour.

Staff utilized sign language, hand gestures and a few words in his spoken language to communicate with Resident #1 while they were attempting to provide care to Resident

#1, but indicated that frequently they did not understand what he was trying to communicate to them due to the language barrier.

Sometimes staff would contact Resident #1's spouse so that she could calm him down or find out why he was crying or agitated. This happened on occasion but was not part of any formalized strategy for communicating with Resident #1.

Interviews with staff identified a lack of effective communication tools in the home to meet the needs of residents' whose primary or only language is that spoken by Resident #1, and who are unable to converse and comprehend English.

When interviewed, the Nurse Manager confirmed there were no staff assigned to the identified unit that could converse in or comprehend that language despite the fact that other residents resided on the identified unit, in addition to Resident #1, spoke that language.

The Acting DON indicated that communication tools have been developed to support effective communication with individuals who speak languages other than English in the home. These tools are to be available at each nursing station and posted in resident rooms in their language spoken. When requested to provide these tools in the specific language spoken by Resident #1 for the identified unit, the home was unable to locate these tools for staff use.

When interviewed, staff on the identified unit revealed the names of 2 additional residents who speak this language and little to no English. A visit to the rooms of Resident #9 and #10 revealed there were no communication tools posted in their spoken language, neither were any communication tools posted at the nurses' station on the identified unit.

A review of the home's policy and procedure, Communication Methods - Policy number RC-0401-00 last revised on November 1, 2011 and Interpreter List - Policy number EM-0204-00 last revised on April 1, 2013 indicated the home is to have access to interpreters for communication purposes when communicating with residents during the provision of care.

A review of the 2013 Interpreter List for use by staff when communicating with residents who cannot communicate in the language or languages used in the home during the provision of care failed to reveal any individuals who could provide

interpretive services in the language spoken by Resident #1.

There was no attempt to access interpretative support other than family members to assess Resident #1's psychological well being during emotional upsets or at any other time.

The home failed to arrange for an interpreter to assist the psychiatrist during an assessment of Resident #1, when specifically requested by the psychiatrist. [s. 43.]

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

Findings/Faits saillants :

1. The Licensee failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

A review of Resident #2's plan of care last updated in September 2013 does not set out clear direction to staff and others who provide direct care to the resident related to impaired communication that was as a result of a language barrier.
Resident #2 spoke a language other than English and expressed a few words in English consisting of "thank you" and "no". At other times he communicated his needs through gestures and by making an audible sound. The resident's plan of care does not include any direction on how to ascertain or respond to Resident #2's needs when he is attempting to communicate with gestures or the audible sound. When interviewed, staff stated the audible sound could mean a number of different things. Staff providing direct care said they tried to use gestures or ask a staff member who

spoke the resident's spoken language to come and translate so they could figure out what the resident needed or was trying to communicate.

On November 9, 2013 at approximately 0645 hours a Day Staff (#S131) heard audible sounds coming from the identified resident room. Upon entering the room the Day Staff (#S131) observed Resident #2 lying in bed calling out. The Day Staff (#S131) spoke to Resident #2 asking if he was hungry and provided reassurance indicating she would be back later to get him ready for breakfast. Resident #2 calmed down when she reassured him that she would return later. The Day Staff (131) proceeded to the change of shift report which commenced at 0700 hours. The Day Staff (#S131) did not return to the identified resident's room to provide care to Resident #2 until approximately 0815 hours at which time she found him lying in bed motionless and covered in blood.

The written plan of care for Resident #51 fails to provide clear direction to staff related to strategies to deal with insomnia and the provision of continence care on the night shift.

a) Insomnia/Sleeplessness section says to encourage the use of past measures that have been successful to promote sleep, but the past measures are not articulated in the plan of care. Another strategy recorded under this section directs staff to decrease environmental stimuli i.e. light, noise while indicating to leave the nightlight on in the washroom. Documentation under this section also directs staff to toilet resident prior to bed and to follow toileting routine during the night to maintain continence, however there is no toileting routine documented for the night shift.

b) Continence Care Level Assistance- Urinary Incontinence section states at night, not toileted. When interviewed staff confirmed resident is toileted and brief changed when Resident #51 is wandering on the night shift.

c) Activities of Daily Living Assistance- Toileting section indicates at night resident is totally dependent on one staff to change incontinent brief and give hygiene care.
The written plan of care does not provide clear direction to staff related to the toileting regime for Resident #51 on the night shift which has been identified as a trigger for the resident's insomnia and wandering behaviours.
PLEASE NOTE: This evidence of non – compliance was found during Inspection # 2013_109153_0029. [s. 6. (1) (c)]

2. The Licensee failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

A review of the written plan of care for Resident #1 which was last updated October 2013 indicated the following strategies to respond to the resident's identified needs:

a) Cognitive section states resident is to repeat instructions with a goal to participate in the activities of daily living.
Interviews with staff revealed that Resident #1 spoke and understood a language other than English but experienced great difficulty in understanding or conversing in the English language. At times he would attempt to push staff away and refuse to have care provided. During periods of increased confusion, agitation and wandering Resident #1 would verbalize his anxieties in his spoken language.
A review of the Resident Assessment Protocol Communication (RAP) dated October 2013 indicated Resident #1 speaks and understands a language other than English, and little English.
The strategy to have the resident repeat instructions so he can participate in the activities of daily living fails to ensure that the care set out in the plan of care is based on an assessment of Resident #1's needs and preferences when he is unable to converse in English.

b) Communication section states staff are to use short and direct phrases when talking to Resident #1, instruct resident and family in use of assistive device and praise resident for use of assistive device. The plan of care for Resident #1 does not identify the assistive device to be utilized when communicating with this resident. Through record review and staff interviews it was identified the resident did not use an assistive device for communication.

c) Activities of Daily Living Assistance section indicates use of a cane for mode of locomotion for Resident #1, however interviews with the staff confirmed Resident #1 did use a walker for mobility and not a cane as indicated in the written plan of care. Resident #1 was assessed by the physiotherapist to be high risk for falls due to an unsteady gait. The physiotherapist assessed Resident #1 as needing a walker for mobility. In February 2013 Resident #1 was provided a walker for locomotion. The plan of care was not revised to reflect the assessment of mobility by the physiotherapist and the resident's use of a walker for mobility for Resident #1.

d) Mood State section indicates a strategy to deal with Resident #1's mood

persistence was to allow the resident to talk about feelings of loss. It is not clear as to how this strategy could be effective when the resident speaks and understands a language other than English and little English and there are no staff on the identified unit who converse in this resident's spoken language as confirmed by the Acting Nurse Manager when interviewed. The plan of care for Resident #1 is not based on an assessment of the resident's needs related to the strategy to manage his feelings of loss. [s. 6. (2)]

3. The Licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

This finding of non-compliance is supported by the facts set out in the Summary of Facts and the following:

Resident #1's plan of care directs the care team to provide a consistent caregiver as a strategy to manage his cognitive loss, mood disorder and behaviours along with a direction he was not to be toileted at night time.

The night shift commenced at 2300 hours on November 8, 2013 and ended at 07:00 hours on November 9, 2013. Resident #1 slept most of the night.
At 0530 two Night Staff (#S113 and #S119) entered the identified room to provide care to Resident #1 and Resident #2. One of the Night Staff (#S113) went to Resident #1's bedside, turned the lights on and said good morning which caused the resident to wake up. Resident #1 sat up on the edge of the bed muttering in his spoken language which the staff member could not comprehend. The Night Staff (#S113) was recently hired by the home, and had never provided care to Resident #1 and Resident #1 had never met this staff member until that moment. The Night Staff (#S113) introduced self and attempted to explain in English the care that was going to be provided. When the Night Staff (#S113) attempted to provide care to Resident #1 he began waving his hands/arms as if to push the staff member away and said, "No,No".
The other Night Staff (#S119) who was providing care to Resident #2 directed the NIght Staff (#S113) to leave Resident #1 alone if he was refusing to have care provided and indicated he had also refused to have care provided on the previous night shift. Both Night Staff (#S113 and #S119) left the room and continued with the completion of the early morning round.

A review of the clinical health record for Resident #2 identified a physician order from November 2012 that requested psychiatry to assess the resident.

Interviews with the Behavioural Support Nurse and the Attending Physician confirmed that the physician referral was not forwarded for processing which resulted in a psychiatric assessment not being completed for Resident #2. [s. 6. (7)]

4. The Licensee did not ensure that Resident #1 and #2 were reassessed and the plans of care reviewed and revised at any time when the residents' care needs change and when the care set out in the plan of care has not been effective.

This finding of non-compliance is supported by the facts in the Summary of Facts and the following:

A review of the written plan of care for Resident #1 which was last updated October 2013 under the Behaviour section related to pacing and wandering indicated the following;
- involve resident and family in developing a care contract
- provide diversional activities
- encourage involvement in activities
- remove resident from other residents' rooms to prevent altercations

Interviews with staff confirmed Resident #1 did not participate in activities, no longer exhibited wandering behaviour or had exhibited any physical aggression toward others prior to the incident that occurred on November 9, 2013. The resident began territorial behaviours, as identified during staff interviews, including sitting for long periods of time in front of his room, keeping the door closed, taking steps to keep people out of his room and refusing to go to the dining room for meals. Resident #1 was not reassessed for these behaviours and his plan of care was not reviewed or revised.
When interviewed the Acting DON indicated to develop a care contract was not an effective strategy for this resident.
Resident #1 was not reassessed and the plan of care reviewed and revised when the resident's care needs changed or when the care set out in the plan was no longer effective.

During the incident on November 9, 2013 multiple staff observed the change in condition of Resident #2 who was covered in blood, pale and did not appear to be breathing. Only one Day Staff (#S122) attempted to find a pulse. Other Day Staff (#S100,#S107,#S129) noted that he did not appear to be breathing.
The Day Staff confirmed during interviews that no additional assessments of the

resident's health status were completed to determine whether life was sustainable.
A review of Resident #2's progress notes and the home's internal investigation notes confirmed that the staff did not reassess the resident when there was a significant change in the resident's condition after the incident on November 9, 2013.

A review of the home's policy and procedure - Care of the Body After Death - policy number - NU-0803-00 last revised on December 1, 2010 related to assessing signs of death - the staff are to ensure cessation of the apical pulse, respiration and blood pressure, absence of reflex activity, movements and respiration, with pupil fixed and dilated.
When interviewed the Acting DON indicated the licensee's expectation is to have the registered staff reassess any resident with a significant change in health status consistent with the home's policy. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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;
- there is a written plan of care for each resident that sets out clear direction to staff and others who provide direct care to the resident
- the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident
- the resident is reassessed and the plan of care reviewed at any other time when the resident's care needs change, to be implemented voluntarily.

WN #3: 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 failed to protect Resident #2 from abuse by Resident #1 as shown by the Summary of Facts and the following:
1. The Licensee failed to protect Resident #2 from physical abuse. The applicable definition of physical abuse in O. Reg. 79/10 of the LTCHA is "the use of physical force by a resident that causes physical injury to another resident."
As described in the Summary of Facts, on November 9, 2013 Resident #1 physically abused Resident #2.

2. The Licensee failed to protect residents, in particular Resident #2, from abuse through a pattern of inaction and/or inappropriate and/or insufficient action that is shown by the following:
a) Although Resident #1 did not have a significant history of violent or aggressive behaviours, other than incidents noted in paragraph 4 and 5 of the Summary of Facts, he did have a recent history of paranoia, hallucinations and periods of agitation. Between February 2013 and November 7, 2013 he was seen by a psychiatrist on 5 separate occasions and assessed by the in-house Behaviour Support Team.

b) From the time of admission until the incident on November 9, 2013 Resident #1 was taking a combination of medications. The dosages and types of medications were adjusted throughout that period by both the psychiatrist and the attending physician as they sought to manage his symptoms and behaviours.

c) Resident #1 shared a room with Resident #2. Resident #2 was frail and required extensive assistance with the activities of daily living. He could not ambulate, including get in or out of bed, without assistance. Resident #1 also required assistance with the activities of daily living, but he was mobile and used a walker.

d) Resident #1's wandering tendencies lessened as he adjusted to the home and as his medications were adjusted. His behaviours turned territorial and staff noted that he could most frequently be found sitting on a chair in front of their room or pacing inside their room. He would implement measures to keep people out of their room, though he usually permitted staff he knew to enter without difficulty. Those measures included shouting, pushing his walker towards others, redirecting other residents who were attempting to enter the room and keeping the door closed on a consistent basis. As described in WN #5, the licensee failed to identify these behavioural triggers and did not assess the resident for these territorial behaviours that would also have potentially had an impact on Resident #2 as his roommate.

e) Resident #1 demonstrated responsive behaviours, including wandering, agitation, crying and refusal of care at various points in time between the time of admission and November 9, 2013. During those periods, Resident #1 would speak or mutter in a language other than English. The staff could not understand him. As described in WN #1, there were no communication tools or staff interpreters available to facilitate communication with Resident #1 to determine the cause for these behaviours and to assist the resident in communicating his needs. On some occasions staff would contact Resident #1's spouse so that she could comfort or calm him. This happened infrequently, inconsistently and was not part of any formalized strategy for communicating with Resident #1.

f) Between the end of May and August 2013, Resident #1 exhibited infrequent episodes of crying and agitation. The physician changed Resident #1's drug regime to manage these behaviours.

g) Near the end of August 2013, Resident #1 shared with his family in his spoken language, that he did not feel safe. He told his family that people were being killed in the home and feared he would be next. The family attempted to reassure the resident he was safe and reported this to a registered staff member who also attempted to reassure Resident #1 of his safety. The attending physician was notified and prescribed changes to the resident's medications.
Resident #1's family continued to report to staff that Resident #1 was paranoid and experiencing hallucinations. Staff did not know he was experiencing paranoia and hallucinations other than through family members. The resident only spoke a language other than English and the staff could not understand what he was saying.

h) In conducting assessments, the psychiatrist relied, in part, on staff documentation of Resident #1's condition between visits. When the psychiatrist could not rouse the resident during a visit, the psychiatrist had to rely more heavily on the information provided by staff. The staff could only document the physical manifestation of the resident's behaviours and conditions. They could not understand him and so could not assess his state of mind or understand the causes of any periods of agitation or weepiness, unless the surrounding circumstances provided enough clues for staff to draw a conclusion. They were not able to identify, for example, whether he was having hallucinations. The staff did not take steps to adequately monitor the resident's condition to assist the psychiatrist in assessing Resident #1.

i) As described in WN #1, the licensee's staff failed to arrange for an interpreter to

assist the psychiatrist during the assessments of Resident #1 after being asked to arrange one. When the psychiatrist assessed Resident #1 on November 7, 2013, two days before the incident, there was no interpreter present.

j) The staff failed to reassess Resident #1's psychological well-being to ensure he was not placing himself and others at risk when he demonstrated frequent episodes of crying, refusals to have care provided and refusal to come down for dinner between the evening of November 7, 2013 and the morning of November 9, 2013. No one took any steps to communicate with Resident #1 to understand why he was weepy, refusing care and refusing to go to the dining room for dinner over this extended period of time.

3. In addition to the above, the Licensee failed to protect residents, in particular Resident #2, from abuse by Resident #1 on November 9, 2013 as follows:
a) Resident #1's plan of care directs the care team to provide a consistent caregiver as a strategy to manage his responsive behaviours. Contrary to the care as set out in the plan of care and notwithstanding that the resident had been resistive to care and/or weepy starting the previous night and throughout the prior day and evening, a Night Staff (#S113) who was new to the home and unknown to the resident, was directed to provide care to Resident #1 on the morning of the incident. At 0530 hours the Night Staff (#S113) went to his bedside, turned on the lights and said good morning, which woke him up. He sat up on the edge of the bed muttering in his spoken language, which neither staff member present could understand or made any attempt to understand. The Night Staff (#S113) introduced self and attempted to explain in English the care that was going to be provided. When the Night Staff (#S113) proceeded toward the resident in an attempt to provide care, he began waving his hands/arms as if to push the Night Staff 113) away and refused care.

b) On November 9, 2013 at approximately 0645 hours a Day Staff (#S131) heard an audible sounds coming from Resident #1 and Resident #2's room. Upon entering the room the Day Staff (#S131) observed Resident #2 lying in bed calling out. The Day Staff (#S131) spoke to Resident #2 asking if he was hungry and provided reassurance, indicating the staff member would be back later to get him ready for breakfast. The Day Staff (#S131) observed Resident #1 lying quietly on his bed. The Day Staff (#S131) left the resident room and proceeded to the change of shift report which commenced at 0700 hours. The Day Staff did not return for an hour and a half at which time the staff discovered the abuse.

c) Between 0700 and 0730 hours that morning, during the morning report, there was no staff assigned to, or present on the identified unit.

d) When staff discovered the physical abuse, there was a disorganized approach to handling the emergency. Staff was unable to point to or provide policies and procedures that would direct staff in how to handle this type of emergency. Nobody called a Code White that morning. Staff interviewed about this said there was no perceived threat and the incident was not in progress, so Code White did not apply. The licensee's Code Blue policy says that it applies to medical emergencies involving staff, but there are no procedures for how to respond to medical emergencies involving residents. The procedures specifically state that they apply "if the victim is anyone other than a resident."

e) As described in WN#2, multiple staff attended in the room from the time of discovery of the abuse. Only one Day Staff (#S122) attempted to find a pulse, but was unable to find one. Two Day Staff (#S122 and #S129) noted that Resident #2 did not appear to be breathing because they could not see his chest rising and did not take any other steps to determine whether he was breathing. No staff completed a head to toe assessment of Resident #2 or administered any form of first aid. Day Staff confirmed that no additional assessments were done to determine whether life was sustainable.

f) Staff violated their own Vital Signs policy, which says that they are supposed to monitor vital signs "as indicated by change in individual residents' conditions." They failed to take steps to check vital signs to determine the cessation of the apical pulse, respirations and blood pressure and the absence of reflex activity, movements and respirations, and check whether the pupils were fixed and dilated, which are all signs of death according to the Licensee's Care of the Body After Death policy.

4. The Licensee failed to ensure that Resident #2 was not neglected by the licensee or staff. Neglect is defined in s. 5 of O. Reg. 79/10 as "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." This finding of non-compliance is supported by the facts set out in the Summary of Facts, in WN#1 and facts set out above, all of which demonstrate the following:

a) The licensee failed to ensure that Resident #1 was properly monitored given his

history of psychological conditions and responsive behaviours. There were no strategies in place to properly monitor his state of mind or determine causes of his responsive behaviours given the language barrier.

b) When Resident #1 demonstrated responsive behaviours, there were no tools or staff or other interpreters, other than the sporadic, infrequent, inconsistent assistance of family members, to facilitate in determining the cause for these behaviours and to assist the resident in communicating his needs.

5. The Licensee failed to protect Resident #101 and # 105 from abuse by anyone as shown by the following:
The applicable definition of physical abuse in O. Reg. 79/10 of the LTCHA is "the use of physical force by anyone other than a resident that causes physical injury or pain."
The applicable definition of emotional abuse in O. Reg. 79/10 of the LTCHA is " any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident."
The applicable definition of verbal abuse in O. Reg. 79/10 of the LTCHA is "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident."

The finding of non-compliance for Resident #101 is supported by the following:

a) In June 2013 Resident #101 reported to the registered staff that an identified staff member struck the resident when she attempted to remove washcloths for evening care from the linen cart.

b) Interview with the registered staff indicated the resident was assessed at the time of the incident, no injuries were noted and there were no behaviour changes as a result of the incident.

c) Review of the resident #101's plan of care and interview with the registered staff indicated that the resident requires limited assistance of one staff for personal hygiene as resident is highly involved in own care.
The nurse in charge was notified of the incident and the identified staff member was reassigned to provide care to other residents on the unit which potentially placed other

residents at risk.
During an interview with the resident in December 2013 the resident could still clearly recall the events of the incident.
PLEASE NOTE: This evidence of non – compliance was found during Inspection # 2013_207147_0029.

The finding of non-compliance for Resident #105 is supported by the following:

a) Review of the resident #105's plan of care and interview with the registered staff indicated the resident requires extensive assistance of two staff related to bathing and that the resident's mode of locomotion is via wheelchair.

b) In September 2013 staff overheard slapping sounds and the resident crying and screaming from inside of the shower room while two identified staff were providing care to the resident. Later while an identified staff was transporting the resident out of the shower room back to Resident #105's room, other staff on the unit overheard the identified staff member verbalize a derogatory comment to the resident.

c) Review of the home's internal investigation notes and interview with the staff indicate that these allegations of physical and verbal abuse were not reported to the home by the registered staff, therefore the home did not start their investigation into these allegation until 2 weeks after the incident. There was no immediate assessment completed by the registered staff at the time of the incident.

d) Interview with the resident with the assistance of an interpreter in December 2013 indicated that the resident could not recall the incident that occurred in September 2013 and the resident was happy with the care and services provided by the staff.
As a result of the home's internal investigation the PCA involved received disciplinary action.
PLEASE NOTE: This evidence of non – compliance was found during Inspection # 2013_207147_0029. [s. 19. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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 failed to ensure the plan of care for Resident #1 was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident's mood and behaviour patterns, including any potential behavioural triggers and variations in resident functioning at different times of the day.
The Responsive Behaviour plan of care for Resident #1 is not based on an interdisciplinary assessment of the resident related to territorial behaviours.
Interviews with staff, family and a review of the progress notes indicated the resident sat outside of his room most of the day to be watchful of who entered his room and would prevent individuals from entering his room by constantly keeping his door closed.
When other residents wandered into his room he would initiate measures to redirect them out and away from his room. These measures included shouting, pushing his walker towards others, redirecting other residents who were attempting to enter the room and constantly keeping his door closed.
A record review along with interviews failed to indicate an interdisciplinary assessment had been completed for Resident' #1's territorial behaviour.
A plan of care had not been developed and implemented to manage this behaviour.
[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 a plan of care must be based on at a minimum,interdisciplinary assessment of the following with respect to the resident's mood and behaviour patterns including any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The Licensee failed to ensure that, for each resident demonstrating responsive behaviours that the behavioural triggers for the resident are identified, where possible.

Resident #1 demonstrated responsive behaviours including territorial behaviours which resulted in agitation.
Interviews with staff, family and a review of the progress note indicated the resident sat outside of his room most of the day to be watchful of who entered his room and would implement measures to prevent individuals from entering his room. Those measures included shouting, pushing his walker towards staff, redirecting other residents when attempting to enter his room and keeping the door to his room closed on a consistent basis.
The Responsive Behaviour plan of care for Resident #1 is not based on an interdisciplinary assessment of the resident related to territorial behaviours.
This behavioral trigger was not identified on Resident #1's plan of care. [s. 53. (4) (a)]

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 for each resident demonstrating responsive behaviour that the behavioural triggers for the resident are identified where possible, to be implemented voluntarily.

Issued on this 12th day of March, 2014

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

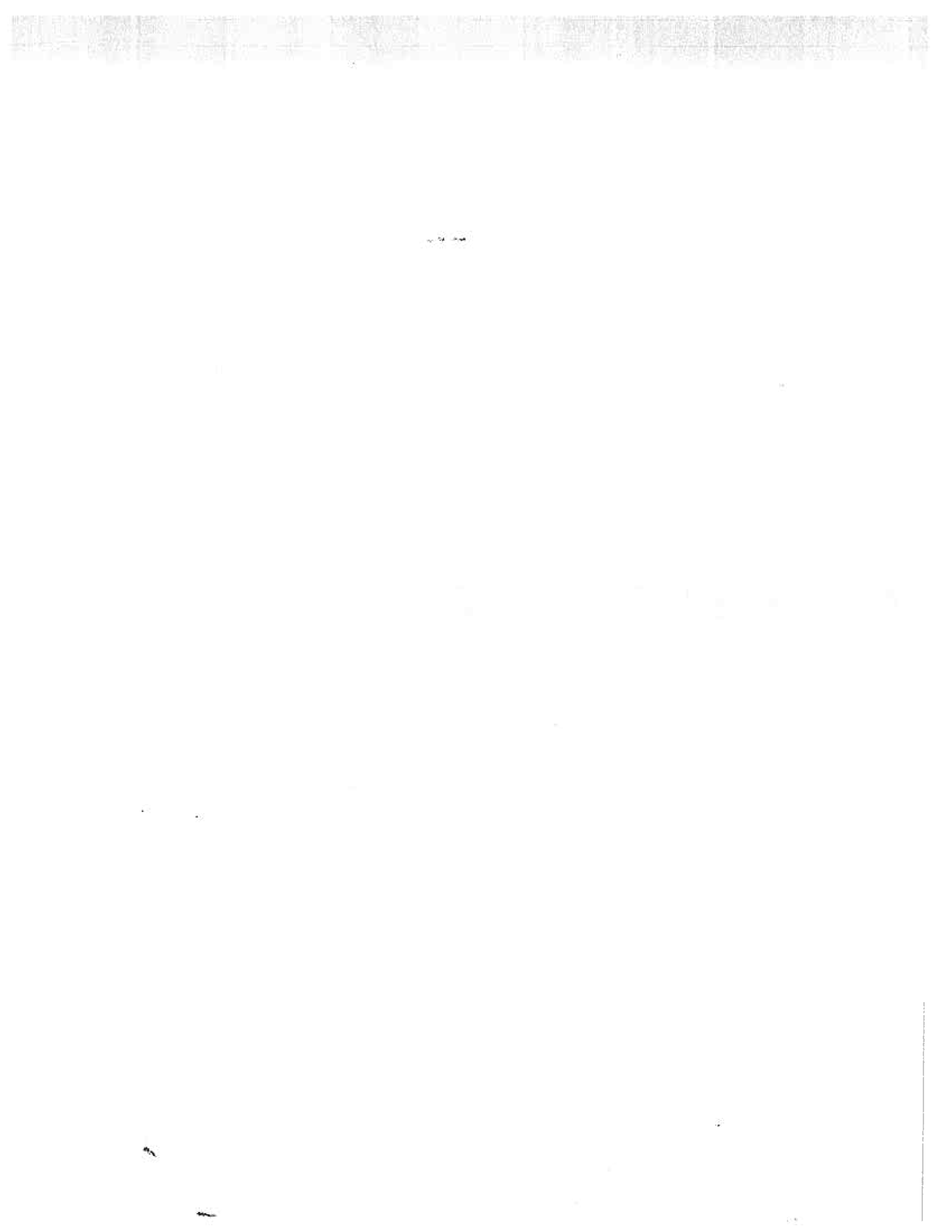
Additional Required Actions:

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 for each resident demonstrating responsive behaviour that the behavioural triggers for the resident are identified where possible, to be implemented voluntarily.

Issued on this 12th day of March, 2014

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

Lynn Parsons



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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNN PARSONS (153), LALEH NEWELL (147)
Inspection No. / No de l'inspection :	2013_109153_0027
Log No. / Registre no:	T-640-13
Type of Inspection / Genre d' inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 27, 2014
Licensee / Titulaire de permis :	TORONTO LONG-TERM CARE HOMES AND SERVICES 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
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Nancy Lew

To TORONTO LONG-TERM CARE HOMES AND SERVICES, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Order / Ordre :

The Licensee shall prepare, submit and implement a plan to develop and implement strategies to meet the needs of residents with compromised communication and whose spoken language is not English.

This plan is to be submitted via email to inspector - M. Lynn.Parsons@ontario.ca by March 14, 2014.

Grounds / Motifs :

1. The Licensee failed to ensure strategies are implemented to meet the needs of residents with compromised communication including residents who cannot communicate in the language or languages used in the home.
As indicated in the Summary of Facts and the Inspection Report:

a) The Licensee failed to comply with s. 43 of O. Reg. 79/10.

b) Resident #1 was identified with compromised communication and a language barrier.
Resident #1 spoke and understood a language other than English but experienced great difficulty in understanding or conversing in the English language and would try to communicate with staff using hand gestures.

c) During periods of increased confusion,sadness and agitation Resident #1 would verbalize anxieties by muttering in a language other than English, which the staff could not understand.
It was only when a family member informed the staff the resident was

experiencing hallucinations and paranoia that the staff became aware of the resident's state of mind and notified the physician.

d) The plan of care last revised in October 2013 does not include any implemented strategies to meet Resident #1's needs related to language spoken and understood other than using non-verbal communication techniques including the use of short, direct phrases and maintain eye contact.

e) There was a lack of effective communication tools in the home to meet the needs of residents' whose primary language is other than English, and who are unable to converse and comprehend English.

f) There were no staff assigned to the identified unit that could converse in Resident #1's spoken language.

g) The home's policy and procedure, Communication Methods - Policy number RC-0401-00 last revised on November 1, 2011 and Interpreter List - Policy number EM-0204-00 last revised on April 1, 2013 indicated the home is to have access to interpreters for communication purposes when communicating with residents during the provision of care.
A review of the 2013 Interpreter List for use by staff when communicating with residents who cannot communicate in the language or languages used in the home during the provision of care failed to reveal any individuals who could provide interpretive services in Resident #1's spoken language.

h) There was no attempt to access interpretative support other than family members to assess Resident #1's psychological well being during emotional upsets or at any other time.

i) The home failed to arrange for an interpreter to assist the psychiatrist in the assessment of Resident #1, even when specifically requested by the psychiatrist. (147)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 16, 2014

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The Licensee shall prepare, submit and implement a plan to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, including but not limited to the following tasks:
1. Develop an ongoing process to monitor and evaluate the care provided to residents to ensure it is consistent with the care set out in the plan of care;
2. Incorporate the ongoing process to monitor the care provided to residents into the Home's Quality Improvement Program;
3. Re-educate registered staff on the policy and procedure for processing referrals for psychiatric consultations.

The plan should identify who will be responsible for completing all of the identified tasks and when these tasks will be completed.

The plan is to be submitted via email to inspector - M.Lynn.Parsons@ontario.ca by March 14, 2014.

Grounds / Motifs :

1. The Licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.
As indicated in the Summary of Facts and the Inspection Report:

a) LTCHA s.6(7) was previously issued in the following inspections, # 2013_103193_002, # 2013_108110_001 and # 2011_193_9510_26.

b) Resident #1's plan of care directs the care team to provide a consistent caregiver as a strategy to manage cognitive loss, mood disorder and behaviours.
On November 8, 2013 the night shift commenced at 2300 hours and ended at 07:00 hours on November 9, 2013 , a Night Staff who had never provided care to Resident #1 prior to the round at 0530 hours was directed to provide care to Resident #1.

c) A review of the clinical health record for Resident #2 identified a physician order from November 2012 that requested psychiatry to assess the resident. Interviews with the Behavioural Support Nurse and the Attending Physician confirmed that the physician referral was not forwarded for processing which resulted in a psychiatric assessment not being completed for Resident #2. (147)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 23, 2014

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Order / Ordre :

The Licensee shall:
1. Develop and implement a staffing strategy to ensure residents are monitored during the change of shift report;
2. Develop and implement a communication strategy that facilitates ongoing communication and supports the assessment and treatment of a resident's psychological well-being who converse in a language other than English;
3. Ensure that any tools and or services included in the above communication strategy are accessible and available to staff when required;
4) Develop and implement a plan to facilitate the assessments of psychiatrists and other physicians, in particular where the resident being assessed does not speak the language of the assessor;
5) Amend the Code Blue policy to set out procedures to deal with medical emergencies involving residents that sets out plan activation, lines of authority, communications plan and specific staff roles and responsibilities, including how staff will ensure assessment of residents for signs of life;
6) Train staff on the revised Code Blue policy or the policy that is developed to deal with medical emergencies;
7) Develop and implement processes to ensure an immediate investigation is commenced after a report of any abuse by anyone and that the abuser is removed from the home immediately pending investigation.

The licensee shall prepare, submit and implement a plan for complying with Orders 1 - 7 and identify who will be responsible for completing all of the tasks identified in these Orders and when the Orders will be complied with.

This plan is to be submitted via email to inspector - M.Lynn.Parsons@ontario.ca by March 21, 2014. The date for complying with Orders 1 - 7 shall not be later than April 30, 2014.

Grounds / Motifs :

1. The Licensee failed to protect Resident #2 from physical abuse.
LTCHA s.19(1) was previously issued as a Compliance Order for inspection # 2013_103193_0002 on April 5, 2013 and inspection # 2011_162_9510 05Apr121248.

2. As set out in the Summary of Facts and the Inspection Report:
a. The Licensee failed to protect residents from abuse by anyone pursuant to s. 19 of the LTCHA and the particulars are described in the inspection report;

b. The Licensee failed to comply with s. 6(1)(c), 6(2), 6(7) and 6(10)(b) of the LTCHA;
c. The Licensee failed to comply with s. 26(3)(5) of O. Reg 79/10;
d. The Licensee failed to comply with s. 43 of O. Reg 79/10 and
e. The Licensee failed to comply with s. 53(4) of O. Reg. 79/10.

3. The Licensee failed to ensure a staffing strategy was in place to monitor residents on an identified unit during change of shift report.
a) All staff scheduled to work the day shift on the identified unit on November 9, 2013 attended the shift report from 0700 to 0730 hours. The report took longer on this specific day because staff needed to have their resident assignments altered due to the shortage of 1 Day Shift position that could not be replaced. As a result the Day Staff (#S122) assisted with medication administration and the other Day Staff assumed additional resident care assignments.
b) During the change of shift report no staff were assigned or were present in the unit where Resident #1 and Resident #2 resided.

4. The licensee failed to protect residents from abuse through a pattern of inaction and/or inappropriate and/or insufficient action related to compromised communication for residents who cannot communicate in the language or languages used in the home, a disorganized approach to handling an emergency situation and identifying triggers related to responsive behaviours exhibited by Resident #1.
a) In conducting assessments, the psychiatrist relied, in part, on staff documentation of Resident #1's condition between visits. When the psychiatrist could not rouse the resident during a visit, the psychiatrist had to rely more heavily on the information provided by staff. The staff could only document the physical manifestation of the resident's behaviours and conditions. They could not understand him and so could not assess his state of mind or understand the causes of any periods of agitation or weepiness, unless the surrounding circumstances provided enough clues for staff to draw a conclusion. They were not able to identify, for example, whether he was having hallucinations. The staff did not take steps to adequately monitor the resident's condition to assist the psychiatrist in assessing Resident #1.
b) As described in WN #1, the licensee's staff failed to arrange for an interpreter to assist the psychiatrist during the assessments of Resident #1 after being requested to arrange one. When the psychiatrist assessed Resident #1 on November 7, 2013, two days before the incident, there was no interpreter present.

c) When staff discovered the physical abuse, there was a disorganized approach to handling the emergency. Staff was unable to point to or provide policies and procedures that would direct staff in how to handle this type of emergency. Nobody called a Code White that morning. Staff interviewed about this said there was no perceived threat and the incident was not in progress, so Code White did not apply. The licensee's Code Blue policy says that it applies to medical emergencies involving staff, but there are no procedures for how to respond to medical emergencies involving residents. The procedures specifically state that they apply "if the victim is anyone other than a resident."
d) As described in WN#2, multiple staff attended in the room from the time of discovery of the abuse. Only one Day Staff (#S122)attempted to find a pulse, but was unable to find one. Two Day Staff (#S122 and #S129) noted that Resident #2 did not appear to be breathing because they could not see his chest rising, but they did not take any other steps to determine whether he was breathing. No staff completed a head to toe assessment of Resident #2 or administered any form of first aid. Staff confirmed that no additional assessments were done to determine whether life was sustainable.
e) Resident #1 demonstrated responsive behaviours including territorial behaviours which resulted in agitation.
Interviews with staff, family and a review of the progress notes indicated the resident sat outside of his room most of the day to be watchful of who entered his room and would implement measures to prevent individuals from entering his room. Those measures included shouting, pushing his walker towards staff, redirecting other residents when attempting to enter his room and keeping the door to his room closed on a consistent basis.

5. The severity of the harm arising from the non-compliance was very high. On November 9, 2013, Resident #1 attacked and caused serious physical injuries to Resident #2 and Resident #2 died.

6. The scope of the harm and risk of harm arising from the non-compliance is pattern. All residents are at risk of harm where the Licensee fails to protect them from abuse.
a. In the specific circumstances involving Resident #1 the home failed to take sufficient action to ensure the staff had access to interpreters to fully understand Resident #1's psychological well-being and state of mind leading up to the incident on November 9, 2013.
b) In the specific circumstances described in the Inspection Report involving Resident #101 and #105 the home failed to ensure appropriate actions were

taken in keeping the residents safe from physical and verbal abuse by anyone.

(153)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2014

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
Performance Improvement and Compliance 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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
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.

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

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
Direction de l'amélioration de la performance et de la conformité
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 27th day of February, 2014

Signature of Inspector / Signature de l'inspecteur : Lynn Parsons

Name of Inspector / Nom de l'inspecteur : LYNN PARSONS

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