



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

**Health System Accountability and Performance Division
Performance Improvement and Compliance Branch**

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

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

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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 |
|--|---|--------------------------------|--|
| Sep 30, 2014 | 2014_369153_0005 | T-349-14 | Follow up |

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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): August 8, 9, 2014.

During the course of the inspection, the inspector(s) spoke with administrator, assistant administrator, behaviour resource nurse, registered nurse (RN), personal care aides (PCA) and family.

During the course of the inspection, the inspector(s) reviewed clinical health records, staff training records, communication resource binders on several home areas, interpreter list, home policies related to prevention of abuse and code blue; completed observations of staff to resident interactions and communication tools posted in resident rooms.

The following Inspection Protocols were used during this inspection:



Dignity, Choice and Privacy
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Table with 2 columns: Legend and Legendé. Legend includes WN (Written Notification), VPC (Voluntary Plan of Correction), DR (Director Referral), CO (Compliance Order), WAO (Work and Activity Order). Legendé includes Avis écrit, Plan de redressement volontaire, Aiguillage au directeur, Ordre de conformité, Ordres : travaux et activités. The table also contains a detailed description of non-compliance with LTCHA requirements and its translation into French.

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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care sets out clear directions to staff and others who provide direct care.

a) A review of the written plan of care for resident #1 revealed conflicting information related to the use of a commode on the night shift.

activities of daily living section indicates:

- at night, staff provide a commode for the resident to use independently

bowel and urinary incontinence section indicates:

- resident does not use a commode any more at night, also uses toilet at night

scheduled toileting plan indicates:

- resident wears incontinent briefs day and night and does not use commode at night.

An interview with the RN confirmed the written plan of care did not provide clear direction in relation to the use of a commode at night.

b) A review of resident #3's written plan of care indicates the following information:
language section

- other languages spoken – identified resident's spoken language

- preferred language - resident's spoken language

- language for care – English

cultural consideration section



- English.

Resident #3 speaks the spoken language, understands the spoken language and a little English.

Interview with the RN confirmed the plan of care for resident #3 did not provide clear directions pertaining to the language to be used during the provision of care or cultural considerations. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care is based on an assessment of the resident and the resident's needs and preferences of that resident.

a) A review of the written plan of care for resident #2 updated May 2014, indicated the following strategies to respond to the resident's identified needs:

i) unpleasant mood in the morning:

- the strategy was to encourage verbalization.

It is not clear as to how this strategy could be effective when the resident speaks and understands a spoken language and a little English and there is only one staff on the identified unit who can converse in the resident's spoken language as confirmed during staff interviews.

ii) impaired communication:

- the strategy directed staff to adjust tonal voice in order for the resident to hear clearly.

A review of the minimum data set (MDS) assessment indicated resident #2 hears adequately with normal talk, tv and telephone.

There was no information obtained to indicate the resident experiences any hearing deficits.

iii) cognitive loss/dementia:

- the strategy directs staff to provide 1:1 attention/conversation daily approximately 10 minutes each time during care.

It is not clear as to how this strategy could be effective when the resident speaks and understands a spoken language and a little English and there is only one staff on the identified unit who can converse in the spoken language as confirmed during interviews with staff.



An interview with the RN confirmed the plan of care for resident #2 was not based on an assessment of that resident's needs and preferences.

b) A review of the written plan of care for resident #3 which was updated July 2014, indicated the following strategies to respond to the resident's identified needs:

i) mood state:

- the strategies directed staff to spend time with resident daily, involve resident in planning daily schedule and allow resident to talk about loss.

The strategy to spend time with resident daily did not indicate what tasks the staff should perform while spending time with the resident daily.

It is not clear as to how the strategies to involve the resident in planning daily schedule or to allow the resident to talk about loss could be effective when the resident does not speak or understand English and staff are unable to speak the resident's spoken language.

Interviews with front line staff indicated they did not speak or understand the resident's spoken language.

An interview with the RN confirmed these strategies are not based on the assessments of the resident who does not speak English, does not understand others or cannot make self understood as stated in the care plan. [s. 6. (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:

- the care set out in the written plan of care sets out clear directions to staff and others who provide direct care to the residents

- the plan of care is based on an assessment of the residents' needs and preferences, to be implemented voluntarily.



THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/ LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:

Table with 4 columns: REQUIREMENT/ EXIGENCE, TYPE OF ACTION/ GENRE DE MESURE, INSPECTION # / NO DE L'INSPECTION, INSPECTOR ID #/ NO DE L'INSPECTEUR. Rows include LTCHA, 2007 S.O. 2007, c.8 s. 19., O.Reg 79/10 s. 43., and LTCHA, 2007 S.O. 2007, c.8 s. 6. (7).

Issued on this 14th day of October, 2014

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