Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 28, 2014	2014_159178_0027	T-012-14	Resident Quality Inspection

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

SUSAN LUI (178), NICOLE RANGER (189), TIINA TRALMAN (162), VALERIE PIMENTEL (557)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 23, 24, 27, 28, 29, 30, 31, November 3, 4, 2014.

The following Complaint intakes were inspected as part of this RQI: T-690-14, T-1276-14, T-1093-14.
The following Critical Incident intakes were inspected as part of this RQI: T-693-14, T-827-14.
The following Follow Up inspections were conducted as part of this RQI: T-736-14, T-737-14, T-1149-14, T-1228-14.

During the course of the inspection, the inspector(s) spoke with Administrator, Assistant Administrator, Director of Nursing (DON), Manager of Building Services, nutrition managers, nurse managers, registered dietitians (RDs), physiotherapists, registered nursing staff, personal care assistants (PCAs), dietary aides, housekeeping staff, residents, family members of residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
9 WN(s)
6 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2014_159178_0012	178
O.Reg 79/10 s. 69.	CO #001	2014_159178_0006	162
O.Reg 79/10 s. 73. (1)	CO #001	2014_108110_0009	162

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with 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. (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).

Findings/Faits saillants :

1. The licensee has 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. Record review and staff interviews confirm that the written plans of care for several residents did not set out clear directions to staff and others who provide care to the residents, specifically in regards to the type of shower chair to be used for those residents.

Review of the plans of care for 12 residents who require a reclining shower chair to be used for the residents' safety, revealed that the plans of care for three of those residents did not state the need for the use of a reclining shower chair. The plans of care for residents #039, #033, and #061, did not state that the resident requires a reclining shower chair to be used for showers.
Staff interviews confirmed that each of the three residents requires a reclining shower chair to be used to ensure the resident's safety during showering, and confirmed that this fact is not present in each resident's written plan of care.

Non-compliance with s. 6(1)(c) of the Long Term Care Homes Act (LTCHA) was previously identified in inspection #2014_159178_0006, conducted on March 20, 2014 with an order issued. The non-compliance in this case was directly related to a resident's plan of care lacking clear direction in terms of the need for a reclining shower chair to ensure the resident's safety during a shower. In this case, the resident sustained an injury as a result of a fall from a non-reclining shower chair. [s. 6. (1) (c)]

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

Record review and staff interviews confirm that the plan of care for resident #004 indicates that the resident required total assistance from two caregivers for bed mobility, including to turn from side to side while in bed.
Staff interviews confirm that in the early morning hours of May 18, 2014, the resident was moved in bed by one staff member alone. The resident later reported having been handled roughly by the staff member during care, which the resident stated caused discomfort. [s. 6. (7)]

Additional Required Actions:

CO # - 001 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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident # 4 was protected from abuse by anyone.

Staff interviews, resident interview and record review confirm the following:
Resident # 4 was verbally abused and handled roughly during care by a staff member in the early morning hours of May 18, 2014.
The resident reported that the staff member called the resident stupid and swore at him/her. The resident also stated that the staff member pushed and pulled the resident roughly during care, which caused the resident pain. When interviewed, the resident reported that for days after the incident the resident slept poorly because of the fear that the staff member might return and harm him/her.
Staff interviewed stated that the resident's roommate reported that during the incident the staff member was so loud, that the roommate feared for the resident's safety, and left the room to find a nurse in order to report the incident.

Non-compliance to s. 19 (1) was previously identified in the following inspections:
#2014_159178_0012 conducted on May 5, 2014, with a Written Notification (WN) and a Compliance Order (CO) issued related to financial abuse and neglect. This CO was subsequently complied during the present inspection.
Inspection # 2013_109153_0027, conducted on November 19, 2013, with a WN issued.
Inspection # 2013_159178_0022, conducted on September 26, 2013, with a WN and a Voluntary Plan of Correction (VPC) issued.
Inspection # 2013_103193_0002, conducted on March 19, 2013, with a WN and a CO issued, which was subsequently complied on June 12, 2013. [s. 19. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.
On the morning of October 23, 2014, an inspector observed that the door to the garbage chute on the 5W unit was not locked. On closer inspection, the inspector determined that debris had been stuffed into the locking mechanism to prevent the lock from functioning as it should, thereby preventing the door to the chute from automatically locking when the door was closed. This was pointed out to the staff on the unit and the debris was immediately removed and the door locked. In subsequent observations during the inspection period, inspectors found the door to the garbage chute to be locked. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

The home's policy titled Nursing and Personal Care Record (NU-0211-04) indicates the following:

Residents' intake for food and fluid will be documented on the nursing and personal care record (NPCR) immediately after consumption. Personal care aides will document snack, food, fluid and supplement intake on the NPCR immediately after resident's intake. The night shift registered staff will review the completed NPCR form daily to confirm information is complete and notify the Nurse Manager for follow-up.

Record review and staff interviews revealed that resident #032 is at nutritional risk for varied intake and weight loss. The resident is prescribed a nutritional supplement twice daily, and is monitored for intake.

Record review of the resident's NPRC revealed that for the period between June 1 until October 31, 2014, the documentation of the resident's intake of nutritional supplement was incomplete on approximately 59 days.

Interviews with identified PCAs revealed conflicting information regarding the resident's consumption of the nutritional supplement. Some staff indicated the resident usually consumes all of his/her nutritional supplement, while other staff indicated the resident rarely consumes it completely. Furthermore, staff gave inconsistent information as to which staff is responsible to record resident intake of nutritional supplement on the NPCR record.

Interview with an identified nutrition manager (NM) and registered dietitian (RD) confirmed that the staff are not consistently documenting residents' prescribed nutritional supplementation on the NPCR – Food and Fluid intake. The registered dietitian indicated that the documentation serves as a tool to assess resident nutrition status, and when the documentation is not present it makes accurate assessment of the resident more difficult.

The unit nurse manager (NM) confirmed that it is the responsibility of the night RN/RPN to review the completed NPCR form daily to confirm information is complete and notify the Nurse Manager for follow-up. The NM confirmed that this has not been done consistently for the past several months. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that staff complied with the home's policy Medication Administration - General Rules (PH-0203-00), dated January 2012.

The policy requires registered staff to record administration of medication immediately after the medication has been administered, and states that the nurse is to verify that the medication has been swallowed.

On October 31, 2014, the inspector observed the noon medication pass with an identified registered staff member. The inspector observed a medication cup in an identified resident's drawer of the medication cart. The unlabeled cup contained a white tablet. The staff member stated that this was the medication which would be provided to the identified resident at noon. The inspector reviewed the Medication Administration Record (MAR) and observed that the registered staff had already signed for the noon medications in the MAR before they were administered to the resident. When questioned as to what the procedure would be should the resident fail to take the medication, the staff member replied that the resident always takes the medication, and does not refuse. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

On the morning of October 23, 2014, an inspector observed that in washroom #4 on the 5W unit, the toilet was leaking water from the base onto the floor of the washroom. The water ran from the base of the toilet to the doorway of the room. Furthermore, the lock on the door had been covered with duct tape preventing the door from being locked, which created a risk for falls for a resident who might enter the room unsupervised.
On the late afternoon of the same day, when an inspector informed the Administrator of the leaking toilet, the administrator indicated that he/she was aware of the leak.
A week later, on October 30, 2014, an inspector observed that the toilet continued to leak water onto the floor towards the doorway. At this time the washroom door was found to be locked, thereby restricting residents from unsupervised entry.

An interview with the Manager, Supervisor Building Service on October 30, 2014 revealed that he/she had not been made aware of the leaking toilet and he/she indicated that action would be taken immediately.

On October 31, 2014, the inspector observed that the toilet had been replaced and no longer leaked water onto the floor. [s. 15. (2) (c)]

2. Staff and resident interviews confirm that the tub on the 6W unit is not working, and has not been working for some time. Interview with the home's Manager, Supervisor Building Service confirms that he/she was not aware that the tub is not working, and the maintenance department did not receive a maintenance requisition regarding the tub being non-functional. [s. 15. (2) (c)]

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 home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that allows calls to be canceled only at the point of activation.

Observations and staff interviews confirm that on the 2C unit, the resident-staff communication and response system allows the calls to be canceled from a location other than the point of activation.

On October 23, 2014, an inspector activated the call bell at the bedside of an identified resident. The inspector heard the bell chime and saw the light outside the resident's room light up. After a few seconds a voice came over the speaker in the resident's room, and asked what was needed or wanted. The inspector explained that he/she was checking call bells, and the bell was then shut off by someone not in the room, i.e. not at the point of activation. Staff interviews confirmed that the bell had been canceled from the nursing station.

Interview with the home's DOC confirmed that 2C is the only unit in the home where call bells can be canceled at a location other than the point of activation. [s. 17. (1) (c)]

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 home is equipped with a resident-staff communication and response system that allows calls to be canceled only at the point of activation, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs remain in the original labeled container or package provided by the pharmacy service provider until administered to a resident.

On October 31, 2014, an inspector observed the noon medication pass with an identified registered staff member. Prior to beginning the medication pass, the inspector observed an identified resident's medications in an unlabeled medication cup within the resident's bin within the medication cart. The registered staff member confirmed that he/she had "pre-poured" the medications, i.e. he/she had removed the medications from the original container and placed them in the unlabeled medication cup, prior to beginning the medication pass. [s. 126.]

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 drugs remain in the original labeled container or package provided by the pharmacy service provider until administered to a resident, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice.

Staff interviews confirm that resident #061 prefers a tub bath or sponge bath rather than a shower. However, because the tub on the resident's unit is currently not functional, the staff is providing only sponge baths for the resident. The resident does receive a shower when a family member attends and showers him. The identified staff members stated

that the tub on the unit is too old to be fixed, and will need to be replaced, however they were unaware of a date when this work might be initiated. [s. 33. (1)]

2. Resident #011 reported during an interview with the inspector, that the resident prefers to have a tub bath rather than a shower, but the staff are currently providing showers to the resident.

Interviews with front line staff confirm that the resident was previously receiving tub baths, but the tub bath on the unit is not currently functional.
Further interview with the home's DON revealed that the tub is in fact working, although the staff had stated that it was not. [s. 33. (1)]

3. Resident #035 reported during an interview with the inspector, that the resident prefers to have a tub bath rather than a shower, but that staff are currently providing showers to the resident despite the fact that the resident has asked for a tub bath.

Interviews with a front line staff member revealed that the staff member was unaware that the resident prefers a tub bath as the resident is always showered. The staff member stated that he/she does not offer tub baths to the resident because no one on the unit uses the tub. The identified PSW stated that they do not have the equipment necessary to safely transfer the resident into the tub. The unit's nurse manager confirmed that the resident is not able to get into the tub on this unit because it is an older model tub.
The inspector observed the tub room on this unit to contain various non-bath related items, including a folding cot, and a linen cart. [s. 33. (1)]

4. Resident #019 reported during an interview with the inspector, that the resident prefers to have a tub bath rather than a shower. The resident stated that he/she had previously been receiving tub baths in the jacuzzi tub and found it to be very relaxing, however the resident has not received a tub bath in the last six months as the jacuzzi tub is not functional. The resident stated that he/she was told by staff that the home does not have the money to fix the Jacuzzi tub, and the resident now receives showers instead.
Staff interviews confirm that resident #019 previously received tub baths, as did a few other residents on the unit and they were enjoying it, but they are not receiving baths currently as the tub on the floor is not functional.
A follow up interview with the DON revealed that the Jacuzzi tub is in fact functional, but the door does not close smoothly, and a requisition will be submitted for that issue. [s. 33. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area of a medication cart that is used exclusively for drugs and drug related supplies.

During observations of two medication carts on October 31, 2014, the inspector noted various non drug related items being stored in the medication carts and double locked narcotic bins of the carts. These items include 1 envelope of money labeled with a resident's name, denture adhesive wafers and a candy tin labeled with a resident's name. Interview with the unit nurse manager confirmed that these items should not be stored in the medication carts. [s. 129. (1) (a)]

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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

Issued on this 31st day of December, 2014

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

Susan Shi (178)

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
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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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN LUI (178), NICOLE RANGER (189), TIINA TRALMAN (162), VALERIE PIMENTEL (557)
Inspection No. / No de l'inspection :	2014_159178_0027
Log No. / Registre no:	T-012-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 28, 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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_159178_0006, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all residents who require a reclining shower chair for safety, have written plans of care which set out clear directions to staff who provide care to the residents, particularly in regards to the type of shower chair to be used to ensure the resident's safety. The plan will be submitted via email to susan.lui@ontario.ca by December 8, 2014.

Grounds / Motifs :

1. The licensee has 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.
Record review and staff interviews confirm that the written plans of care for several residents did not set out clear directions to staff and others who provide care to the residents, specifically in regards to the type of shower chair to be used for those residents.

Review of the plans of care for 12 residents who require a reclining shower chair to be used for the residents' safety, revealed that the plans of care for three of those residents did not state the need for the use of a reclining shower chair.
The plans of care for residents #039, #033, and #061, did not state that the resident requires a reclining shower chair to be used for showers.
Staff interviews confirmed that each of the three residents requires a reclining shower chair to be used to ensure the resident's safety during showering, and confirmed that this fact is not present in each resident's written plan of care.

Non-compliance to s. 6(1)(c) of the Long Term Care Homes Act (LTCHA) was previously identified in inspection #2014_159178_0006, conducted on March 20, 2014 with an order issued. The non-compliance in this case was directly related to a resident's plan of care lacking clear direction in terms of the need for a reclining shower chair to ensure the resident's safety during a shower. In this case, the resident sustained an injury as a result of a fall from a non-reclining shower chair.
(178)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2014

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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. 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that resident # 4, and all residents in the home, are protected from abuse by staff members during the night shift.
The plan shall be submitted via email to susan.lui@ontario.ca by December 8, 2014.

Grounds / Motifs :

1. The licensee has failed to ensure that resident # 4 was protected from abuse by anyone.

Staff interviews, resident interview and record review confirm the following:
Resident # 4 was verbally abused and handled roughly during care by a staff member in the early morning hours of May 18, 2014.
The resident reported that the staff member called the resident stupid and swore at him/her. The resident also stated that the staff member pushed and pulled the resident roughly during care, which caused the resident pain. When interviewed, the resident reported that for days after the incident the resident slept poorly because of the fear that the staff member might return and harm him/her.
Staff interviewed stated that the resident's roommate reported that during the incident the staff member was so loud, that the roommate feared for the resident's safety, and left the room to find a nurse in order to report the incident.

Non-compliance to s. 19 (1) was previously identified in the following inspections:
#2014_159178_0012 conducted on May 5, 2014, with a Written Notification (WN) and a Compliance Order (CO) issued related to financial abuse and neglect. This CO was subsequently complied during the present inspection.
Inspection # 2013_109153_0027, conducted on November 14, 2013, with a WN and a CO issued, which was subsequently complied on September 30, 2014.
Inspection # 2013_159178_0022, conducted on September 30, 2013, with a WN and a Voluntary Plan of Correction (VPC) issued.
Inspection # 2013_103193_0002, conducted on March 19, 2013, with a WN and CO issued, which was subsequently complied on May 27, 2013.
(178)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 15, 2015

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.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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 28th day of November, 2014

Signature of Inspector / Signature de l'inspecteur : Susan Lui (178)

Name of Inspector / Nom de l'inspecteur : SUSAN LUI

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