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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5700 Yonge Street 5th Floor
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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
Mar 23, 2015	2015_378116_0003	T-2010-15	Other

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

SARAN DANIEL-DODD (116)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): February 12, 13, 17, 18, 19, 20, 2015.

During the course of the inspection, the inspector(s) spoke with the administrator, assistant administrator, director of care (DOC), pharmacist, registered staff members, Chaplin, complementary care assistant and recreation service assistant.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Medication
Responsive Behaviours

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

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

Resident #001 was admitted to the home with a confirmed diagnosis. On an identified date, resident #001 expressed high risk behaviours to staff members of the home. The resident was transferred to the hospital for further assessment and returned to the home.

The written plan of care created upon return from the hospital, directs staff to monitor resident #001 for high risk behaviours. Interventions put in place were to monitor and to remove potentially dangerous objects from resident #001's area.

On an identified date, the resident was observed to be unresponsive, drowsy and lethargic. The resident was transferred to the hospital for further assessment. Subsequently, the resident passed away. The police conducted a search of the

resident's room and discovered a blister pack containing several medications from an external pharmacy.

Interviews held with registered staff members reported conflicting information regarding the directions for monitoring potential dangerous objects within the resident's area. Some staff members reported that they would monitor the resident's whereabouts on an established frequency and would look at the peripheral surface within the room. Other staff reported that they would only ask the resident how he/she was doing, as looking in the resident's room would encroach on his/her privacy.
Interviews with the nurse manager and DOC confirmed that the plan of care does not provide clear directions to staff pertaining to the monitoring and removing of potentially dangerous objects from resident #001's area. [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Resident #001 is a former resident of the home with an identified condition. Review of the health record documents that the resident exhibits responsive behaviours. The resident was referred and assessed by an external specialized resource.

Review of the health record for resident #001 revealed that the resident had a known history of high risk behaviours with medications. A discharge summary from the hospital on an identified date documents that at some point during the resident's course in hospital, the resident was found surrounded by numerous identified medications. Further, a consultation note from the external specialist documents that during a follow up visit conducted on an identified date, the resident indicated that he/she had high risk behaviours recently.

On an identified date, resident #001 expressed high risk behaviours to staff members of the home. The resident was transferred to the hospital for further assessment and returned to the home.

Interviews held with registered staff members, a nurse manager and the DOC confirmed that they were unaware and had no knowledge of the residents high risk behaviour history other than what was presented during the inspection. The written plan of care was not updated until the resident returned from the hospital to include interventions to manage high risk behaviours expressed by the resident.

On a specified date, resident #001 was found in his/her room by a registered staff member to be unresponsive to touch and verbal stimuli. The resident was transferred to the hospital for further assessment. The resident passed away while in hospital. [s. 6. (4) (a)]

3. The licensee has failed to ensure that staff and others who provide direct care to the resident are kept aware of the contents of the plan of care.

Resident #001 was admitted to the home with a confirmed diagnosis. On an identified date, resident #001 expressed high risk behaviours to staff members of the home. The resident was transferred to hospital for further assessment and returned to the home. The written plan of care was developed upon return from the hospital to manage the expression of high risk behaviours and to monitor the resident's whereabouts and surroundings for safety.

The plan of care was updated and interventions put into place upon the resident's return from the hospital to manage the expressions of high risk behaviour. Interviews held with the nurse manager and DOC confirmed that the expectation is that all consultation notes and discharge summaries are reviewed in order to put recommendations and interventions in place for all residents.

Interviews held with registered staff members, nurse manager and the DOC confirmed that they were unaware and had no knowledge of the residents high risk behaviour history other than what was presented during the inspection. [s. 6. (8)]

Additional Required Actions:

CO # - 001, 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 staff and others who provide direct care to the resident are kept aware of the contents of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

The written plan of care for resident #001 identifies that the resident has a confirmed diagnosis that requires the use of a specified medication to manage an identified condition. The physician's order instructs staff to administer the identified medication once per day. Review of the health record revealed and interviews with registered staff members, pharmacist and the DOC confirmed that on an identified date, the medication dosage was not transcribed to the resident's medication administration record (MAR) which resulted in the medication being stopped abruptly on a specified date. Furthermore, the resident was sent out to the hospital and upon return to the home, the medication reconciliation was transcribed incorrectly by the registered staff and pharmacy which resulted in the medication being stopped once again. Upon discovery of the medication error, the identified medication was restarted on an identified date as per the physician's order. This resulted in the resident not receiving the medication over a 13 day duration.

Review of the physician's notes and follow up report from an external specialist documents that the abrupt discontinuation of the identified medication may have precipitated the increase in high risk behaviours presented in the resident [s. 131. (2)]

2. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.
On an identified date, a registered staff member approached resident #001 in his/her room to administer scheduled medications. Upon entry to the room, resident #001 was observed to be unresponsive to touch or verbal stimuli and noted to be drowsy. The resident was transferred to the hospital for further assessment. The resident passed away while in the hospital.

Review of the health record for resident #001 and interviews held with registered staff members confirmed that resident #001 was not prescribed an identified medication. Further review and interviews with staff members revealed that the resident was not authorized to self administer medications. An interview with the DOC confirmed that a self medication administration order is required for residents to self medicate. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

On an identified date, resident #001 was found to be lethargic, drowsy and unresponsive to touch by a registered staff member. The resident was transferred to the hospital for further assessment. Interviews held with registered staff members and the DOC confirmed that the home was kept up to date by the hospital surrounding the significant change in the resident's condition since admission.

The licensee did not inform the Director until four days after resident #001's transfer to hospital when the resident passed away. [s. 107. (3) 4.]

Issued on this 30th day of March, 2015

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

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
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) :	SARAN DANIEL-DODD (116)
Inspection No. / No de l'inspection :	2015_378116_0003
Log No. / Registre no:	T-2010-15
Type of Inspection / Genre d'inspection:	Other
Report Date(s) / Date(s) du Rapport :	Mar 23, 2015
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:

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) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_159178_0027, CO #001;

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 monitoring for the potential of suicide, have written plans of care which set out clear directions to staff who provide care to the residents, particularly in regards to the process to remove potentially dangerous objects from the resident's area.

The compliance plan will be submitted via email to Saran.DanielDodd@ontario.ca by April 17, 2015 .

Grounds / Motifs :

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

Resident #001 was admitted to the home with a confirmed diagnosis. On an identified date, resident #001 expressed high risk behaviours to staff members of the home. The resident was transferred to the hospital for further assessment and returned to the home.

The written plan of care created upon return from the hospital, directs staff to monitor resident #001 for high risk behaviours. Interventions put in place were to monitor and to remove potentially dangerous objects from resident #001's area.

On an identified date, the resident was observed to be unresponsive, drowsy and lethargic. The resident was transferred to the hospital for further assessment. Subsequently, the resident passed away. The police conducted a search of the resident's room and discovered a blister pack containing several medications from an external pharmacy.

Interviews held with registered staff members reported conflicting information regarding the directions for monitoring potential dangerous objects within the resident's area. Some staff members reported that they would monitor the resident's whereabouts on an established frequency and would look at the peripheral surface within the room. Other staff reported that they would only ask the resident how he/she was doing, as looking in the resident's room would encroach on his/her privacy.
Interviews with the nurse manager and DOC confirmed that the plan of care does not provide clear directions to staff pertaining to the monitoring and removing of potentially dangerous objects from resident #001's area. [s. 6. (1) (c)]

(116)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of residents with mental health illnesses including risk for suicidal tendencies so that their assessments are integrated, consistent with and complement each other.

The compliance plan will be submitted via email to Saran.DanielDodd@ontario.ca by April 17, 2015 .

Grounds / Motifs :

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

Resident #001 is a former resident of the home with an identified condition. Review of the health record documents that the resident exhibits responsive behaviours. The resident was referred and assessed by an external specialized resource.

Review of the health record for resident #001 revealed that the resident had a known history of high risk behaviours with medications. A discharge summary

from the hospital on an identified date documents that at some point during the resident's course in hospital, the resident was found surrounded by numerous identified medications. Further, a consultation note from the external specialist documents that during a follow up visit conducted on an identified date, the resident indicated that he/she had high risk behaviours recently.

On an identified date, resident #001 expressed high risk behaviours to staff members of the home. The resident was transferred to the hospital for further assessment and returned to the home.

Interviews held with registered staff members, a nurse manager and the DOC confirmed that they were unaware and had no knowledge of the residents high risk behaviour history other than what was presented during the inspection. The written plan of care was not updated until the resident returned from the hospital to include interventions to manage high risk behaviours expressed by the resident.

On a specified date, resident #001 was found in his/her room by a registered staff member to be unresponsive to touch and verbal stimuli. The resident was transferred to the hospital for further assessment. The resident passed away while in hospital. [s. 6. (4) (a)]

(116)

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

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 23rd day of March, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SARAN Daniel-Dodd

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