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
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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
Oct 6, 2015	2015_440210_0008	022865-15	Resident Quality Inspection

Licensee/Titulaire de permis

City of Toronto
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

SLAVICA VUCKO (210), ARIEL JONES (566), SARAH KENNEDY (605), STELLA NG (507)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 24, 25, 26, 28, 31, September 1, 2, 3, 4, 8, 9, 10, 11, 14, and 15, 2015.

The following complaint intake was conducted concurrently with this inspection: 005454-15.
The following critical incident intakes were conducted concurrently with this inspection: 018769-15, 002317-15, 007102-15, 003778-15, 003476-15, 001539-15, 001069-15, 001480-14.
The following follow ups were conducted concurrently with this inspection: 009851 -15, 9863-15.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Nursing (DON), Nurse Managers (NMs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Care Aids (PCAs), Registered Dietitian (RD), Manager Building Services (MBS), Physiotherapist (PT), Admission Clerk, Manager of Resident Services, Recreation Services Assistant, Dietary Aide, Resident Council representative, substitute decision makers (SDM), residents and family members of residents.The Inspector also reviewed clinical health records, staff schedules, relevant home policies, performed tour of the home, observed medication administration and dining service.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **3 VPC(s)**
- **0 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 #002	2014_159178_0027	210
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #001	2015_378116_0003	210
LTCHA, 2007 S.O. 2007, c.8 s. 6. (4)	CO #002	2015_378116_0003	210

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 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.

Resident #021 reported during interviews with inspector #210 on August 26, 2015, and inspector #566 on September 1, 2015, that he/she prefers to have a tub bath rather than a shower. Further he/she stated that the jacuzzi tub on 7C unit that he/she was previously using has been in disrepair for over a year and he/she has been offered showers since.

A review of the resident's written plan of care for bathing revealed that the resident's preferred bathing type was a shower. During an interview the resident revealed that he/she has never been asked for her bathing preference.

Interviews with PCA #156, registered staff #155 and #122 confirmed that resident #21 was previously receiving tub baths, and the tub bath on the unit has not been functional for the past year.

Observation carried out on September 2, 2015, by the inspector of the four tub rooms on 7C and 7W units with the nurse manager (NM) #122 revealed there were no functioning bath tubs in any of the tub rooms on the 7th floor. The NM #122 indicated if a resident were to request a tub bath at this time, it would be provided on the 6th floor.

An interview with the manager building services (MBS) on September 2, 2015, revealed an unawareness that any of the tubs the 7th floor were not presently functioning. On September 4, 2015, the MBS followed up with an audit of the home's tub rooms which confirmed that the jacuzzi tubs on 7C and 7W were not functional.

An interview with the Administrator confirmed that if an identified tub is out of service, then the staff should find alternate arrangements to offer and accommodate the resident's bathing preferences. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home is bathed at a minimum, twice a week by the method of his or her choice, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents including implementing interventions.

Review of a critical incident (CI) report (#M510-000041-15), submitted by the home on an identified date, revealed that resident #032 and #033 had an altercation on an identified date in 2015. The police were contacted and resident #032 was sent to hospital with a specified injury. He/she returned to the home with no significant medical findings.

Record review of progress notes revealed resident #032 and #033 have had altercations in the past. Previous two altercations occurred on specified dates on an identified unit where they both live.

A review of the clinical record indicated both residents are followed by the Geriatric Mental Health Outreach Team (GMHOT) on regular bases. A note from the GMHOT in resident #033's chart, on identified date in 2014, stated "ensure resident #033 and #032 are always separated". Interview with NM #151 indicated the residents were not separated because neither resident wanted to move from the floor.

An interview with NM #151 confirmed that both residents had remained living on the same unit despite the recommendation the residents be separated. Interviews with identified staff members #132, #133, #151 and #134 confirmed that staff were aware that resident #032 and #033 did not get along, but it was difficult to keep them separate while they both remained living on the same unit.

Interview with NM #151 confirmed that on an identified date in 2015 when the residents had an altercation, the police recommended that resident #032 and #033 live on separate units. Record review confirmed that on identified date in 2015, an internal transfer for resident #033 has been approved by the admissions committee. Interview with NM and the Administrator indicated the process is still on-going which is why both residents still remain living on the same unit.

An interview with the Administrator indicated that it is the home's responsibility to protect residents and confirmed that the home did not separate the residents as per the recommendations, to minimize the risk of altercations and potentially harmful interactions between residents. [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents including implementing interventions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

Interviews with residents #032, #050, #051, #052, #053, #054, #055 and #056 on an identified unit revealed that they are not offered beverages throughout the day.

An interview with staff member #133 revealed that residents are able to help themselves to fluids which are stored in the fridge in the dining area, or they can ask a staff member for help.
Interviews with the identified residents and observations on the unit revealed that not all residents
are capable of helping themselves.

An interview with the Administrator revealed that all residents on the identified unit used to be independent and they had requested that they help themselves to fluids. The

Administrator recognized that the population has changed and all residents should be offered beverages by staff. She confirmed that residents on the identified unit were not offered a beverage in the morning, afternoon and in the evening and revealed that the home will start offering beverages to all residents. [s. 71. (3) (b)]

2. The licensee has failed to ensure that residents are offered a minimum of a snack in the afternoon and evening.

Interviews with residents #032, #050, #051, #052, #053, #054, #055 and #056 on an identified unit revealed that they are not offered a snack in the afternoon and evening.

An interview with staff member #133 revealed that residents are not offered snacks in the afternoon and evening, but if they would like a snack they can ask a staff member or help themselves to something that is left in the fridge on the unit.

Interviews with identified residents and observations on the identified unit revealed that not all residents are capable of helping themselves. Inspector #605 did not observe a snack cart.

An interview with the Administrator revealed that all residents on the identified unit used to be independent and they had requested that they help themselves to snacks. The Administrator recognized that the population has changed and all residents should be offered snacks by staff. She confirmed that residents on the identified unit were not offered a snack in afternoon and in the evening and revealed that the home will start offering snacks to all residents. [s. 71. (3) (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 residents are offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner, and that the residents are offered a minimum of a snack in the afternoon and evening, 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 the policy "Unplanned Weight Change RC-0523 -13" is complied with.

Review of resident #016's weight history record revealed that the resident lost 5.2% body weight over the course of one month in 2015 and there was no documentation that the resident had been re-weighed.

A review of the policy "Unplanned Weight Change RC-0523-13" revised August 1, 2015, revealed that if there is a 2kg change in weight, a resident should be re-weighed.

An interview with registered nursing staff #127 confirmed that resident #016 had lost 5.2% body weight over a period of one month (significant weight loss) and that the resident should have been re-weighed as per the home's policy.

Interview with the DON indicated that the expectation is for staff to re-weigh residents if there is a significant weight change and then refer to the RD. He/She confirmed that the policy "Unplanned Weight Change RC-0523-13" was not followed. [s. 8. (1) (b)]

WN #5: 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 resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all times.

During observations made on August 24 and September 8, 2015, the inspector was unable to locate a resident-staff communication and response system in the 5W unit sun room. An interview with a 5th floor registered staff #165 revealed that the room is used by residents during family care conferences and she was not able to locate a resident-staff communication and response system.

On September 9, 2015, the inspector observed a resident-staff communication and response system unit (without a pull string) on the west wall of the 5W unit sun room in a small gap between the north wall and the fridge. The resident-staff communication and response system was not easily seen and difficult to access, however, it was noted to be functional on testing.

An interview with the Administrator confirmed that the sun rooms on the Wychwood units of floors 3 to 7 are residential areas and should be equipped with a resident-staff communication and response system for resident safety. The Administrator confirmed

that the resident-staff communication and response system in the 5W sun room was not able to be easily seen, accessed and used by residents due to being blocked by the fridge. She reported that the fridge would be moved. On September 10, 2015, the inspector observed staff members rearranging the furnishings in the 5W sun room to ensure that the communication-response system would be accessible. [s. 17. (1) (a)]

2. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents.

On September 8 and 9, 2015, the inspector observed there were no resident-staff communication and response system in the 6W unit sun room. The sun room was observed to be unlocked and accessible to residents.

An interview with a 6W unit registered staff #162 confirmed that there was no resident-staff communication and response system in the identified sun room, and that residents are supposed to use the area with supervision.

An interview with the Administrator on September 9, 2015, confirmed that the sun rooms on the Wychwood side of floors 3 to 7 are residential areas and should be equipped with a resident-staff communication and response system for resident safety. On September 10, 2015, the Administrator confirmed that the 6W unit sun room did not contain a resident-staff communication and response system. Furthermore she indicated the vendor had already been contacted in order to have one installed as soon as possible. [s. 17. (1) (e)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A review of the resident #005's health record revealed the resident had a total of 11 falls in the period of three months, and four post fall assessments were performed. Review of the health record indicated that resident #005 was at risk for falls related to his/her diagnoses. Review of the progress notes revealed that the resident frequently wandered throughout the unit.

Review of the home's "Falls Prevention and Management" policy (RC-0518-21), revised August 1, 2013, indicated that a "Post Fall Assessment Huddle" must be completed after each fall prior to the end of the shift, and any risk contributing factors identified must be followed up by the nurse.

Interview with staff #122, Falls Prevention and Management program lead, confirmed that registered staff are expected to complete the post fall assessment after each fall by using the "Post Fall Assessment Huddle" form in identifying the contributing factors and appropriate interventions to prevent future falls.

A review of the health record and interview with staff #122 confirmed that resident #005 had a total of 11 falls in period of three months in 2015, and the "Post Fall Assessment Huddle" was not completed for seven of the above mentioned falls. [s. 49. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, or wounds, has received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

A review of resident #15's health record including the progress notes revealed that the resident had an alteration in skin integrity that was treated and healed in a period of three months in 2015.

Interview with registered nursing staff #110 and #111 indicated that the expectation is registered staff to conduct a head to toe skin assessment to residents with impaired skin integrity however it was not conducted for resident #15.

A review of the clinical record, including the skin assessments and interviews with registered nursing staff #110, #111 and nurse manager #112 confirmed that resident#15's alteration in skin integrity was not assessed using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity,

including skin breakdown, pressure ulcers, or wounds, has received immediate treatment and interventions to promote healing, and prevent infection, as required.

A review of resident #15's health record indicated he had an alteration in skin integrity during a period of three months in 2015. On an identified date, one month after the appearance of the alteration in skin integrity, the home's wound care nurse assessed it and recommended a treatment. Interview with registered nursing staff #111 revealed the recommendations from the wound care nurse should be confirmed by the physician, transcribed in treatment administration record (TAR) and the treatment started once the supplies are available from pharmacy. A review of the TAR revealed that the recommended treatment was initiated five days after the recommendation by the wound care nurse.

Review of the home's policy "Skin Care and Wound Prevention and Management", dated October, 1, 2010, indicated stage II pressure ulcer to be cleansed and covered with a dressing/treatment as per physician's orders.

A review of the clinical record including progress notes, physician's orders, TAR, and interview with registered nursing staff #111 confirmed that resident #15 did not receive immediate treatment and interventions to promote healing and prevent infection. [s. 50. (2) (b) (ii)]

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, or wounds has been assessed by a registered dietitian who is a member of the staff of the home.

A review of resident #15's health record indicated he had an alteration in skin integrity for a period of three months in 2015.

A review of the resident #15's clinical record including the nutrition and hydration record revealed the resident was assessed two months after the occurrence of the altered skin integrity, by the nutrition manager as not having pressure ulcers stage I/II/III/IV or open areas. An interview with registered nursing staff revealed that a referral was not sent to RD for assessment because the resident was not at high risk for nutrition and hydration, and he/she had a good appetite.

An interview with RD indicated that the expectation is residents with altered skin integrity to be referred to RD for nutrition and hydration assessment and confirmed that a referral

for the resident #15's pressure ulcer was not sent when the resident had stage II pressure ulcer.

A review of the resident #15's nutrition and hydration assessment record for the period of three months, and interviews with registered nursing staff #111 and RD #115 confirmed the resident who had an alteration in skin integrity had not been assessed by the home's registered dietitian. [s. 50. (2) (b) (iii)]

4. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A review of resident #15's health record indicated he an alteration in skin integrity for a period of three months in 2015, that was treated with antibiotics and locally.

Interview with registered nursing staff #111 indicated all pressure ulcers should be assessed weekly and documented in Weekly Ulcer/Wound Assessment Record however the staff was not able to locate the form with the documented weekly assessments for the resident.

A review of the resident #15's weekly wound assessment record and interview with registered nursing staff #111 confirmed that the the resident's altered skin integrity was not assessed weekly. [s. 50. (2) (b) (iv)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home responds in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

An interview with an identified representative of the Residents' Council revealed that the home does not respond in writing to concerns or recommendations brought forward by the council within 10 days of receiving Resident's Council concerns or recommendations.

An interview with the Residents' Council assistant revealed that concern/recommendation forms were being filled out and returned to the Residents' Council binder, but he/she could not confirm that the response was shared with the Resident's Council within 10 days of receiving concerns or recommendations.

An interview with staff #137 confirmed that the responses to Resident's Council concerns/recommendations were written up within 10 days on the response form, but the response was not shared with the Residents' Council until the next monthly meeting.

An interview with the Administrator indicated that the expectation is for the written response to be shared with the Residents' Council within 10 days. [s. 57. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the daily and weekly menus are communicated to residents.

Observation on August 24, 2015, during the 12:00 p.m. meal service revealed that the posted daily and weekly menus did not match.

Interview with dietary aid #136 revealed that the expectation is for the menus to be updated on a daily and weekly basis and confirmed that the daily and weekly menus had not been updated to reflect what residents were offered.

Interview with the DON confirmed that the expectation is for daily and weekly menus to be updated and communicated to residents. [s. 73. (1) 1.]

WN #10: 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. (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 79/10, s. 107 (2).

Findings/Faits saillants :

1. The licensee failed to use the Ministry's method for after hours emergency contact where the licensee is required to make a report immediately under subsection (1) and it is after normal business hours.

Review of the health record including progress notes revealed that resident #003 passed away on an identified date, and the resident's death was considered unexpected.

Interviews with staff #122 and Administrator #103 indicated the critical incident report was completed on the same day of the incident, however, the Ministry was not notified by using the after hours emergency pager.

Review of the home's "Ministry of Health and Long-Term Care Mandatory and Critical Incident Reporting Requirements" policy (HC-0115-00), revised July 1, 2014, stated that immediate notification to the Ministry is required for critical incident of an unexpected death. The policy further stated that the Ministry should be contacted by telephone, email or initiating a critical incident immediately, and use the Ministry's after hours emergency pager number after normal business hour.

Interviews with staff #122 and Administrator #103 confirmed that the Ministry was not notified by using the after hours emergency pager for the critical incident. [s. 107. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all direct care staff receive training in Falls Prevention and Management annually.

Interview with staff #122, the falls prevention and management program lead, confirmed that all direct care staff are required to participate in falls prevention and management training annually.

Review of the staff training record and interview with staff #117 confirmed that 67% of direct care staff did not receive training in falls prevention and management in 2014. [s. 221. (1) 1.]

Issued on this 8th day of October, 2015

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

Original report signed by the inspector.