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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 7, 2016	2016_413500_0003	024756-15	Critical Incident System

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

NITAL SHETH (500)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 29, February 1, 3, 4, 2016.

During the course of the inspection, the inspector(s) spoke with Administrator, Assistant Administrator, Nurse Managers, Registered Dietitian (RD), Nutrition Manager, Registered Nursing Staff, and Personal Support Workers (PSWs).

The following Inspection Protocols were used during this inspection:

Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.

1 WN(s)
0 VPC(s)
1 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. (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 :

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

A review of resident #001's care plan revealed that the resident was at moderate nutritional risk. The goal indicated that the resident received food and fluid based on medical nutrition requirements and texture that can be chewed and swallowed safely. Staff to monitor the resident's ability to feed self and ensure eating strategies are followed as per the care plan. Check for an identified condition and follow the identified condition care plan as applicable.

a) A review of resident #001's progress note dated April 2015 revealed that the resident was sent to the hospital due to the resident being identified with a change in condition.

A review of the hospital discharge summary dated April 2015 revealed that the most responsible diagnosis was a specified condition. The resident was transferred to the hospital due to a change in condition. The recommendation indicated the resident was to be assessed by an identified healthcare provider at the Long-term Care Home.

A review of the resident's clinical record revealed that there was no referral sent to the above mentioned identified health care provider for the assessment as recommended by the hospital.

Interview with RN #100 indicated that the resident was not assessed by the above mentioned identified health care provider.

Interview with Registered Dietitian (RD) #103 indicated that he/she was not aware of an identified health care provider's assessment.

Interview with Nurse Manager #102 confirmed that the referral should have been sent to the identified health care provider for the assessment.

Interview with Nutrition Manager #107 indicated that the home usually follows hospital recommendations and there should have been a referral sent to the identified health care provider for the assessment.

b) A review of resident #001's progress note dated on July 2015 revealed that the resident was observed with difficulties during meal time and a referral was made to the RD.

The inspector did not find a copy of the above mentioned RD referral during a review of the resident's clinical records.

A review of the home's policy #RC-0523-10, entitled "Referral to the Dietitian", reviewed September 1, 2013, indicated to ensure residents receive nutrition care according to his/her assessed needs, and measures care taken to identify and address concerns related to nutrition and the procedure is to complete referral form for assessment by a Dietitian, based on the Dietitian Referral Form.

Interview with RPN #109, revealed that he/she made a referral to the RD and left it in the mailbox in the kitchen area. RPN #109 indicated that he/she left both white and yellow copies of the referral in the kitchen mailbox. The white copy is usually received by the RD and the yellow copy is filed into the resident's chart.

Interview with RD #103 confirmed that he/she did not receive any referral for the resident and therefore did not assess the resident.

Interview with the Nurse Manager #102 confirmed that the yellow copy should be filed in the chart after the white copy is sent to the RD. He/she could not find the yellow copy in the chart for the RD referral. There was no evidence that the RD referral was made.

Interview with the Assistant Administrator indicated that RPN #109 followed the procedure by leaving both yellow and white copies of RD referral into the nutrition manager's mailbox and could not explain how the referral went missing. The RD never received a referral and the resident was not assessed by the RD.

c) A review of Critical Incident (CI) Report indicated resident #001 had an identified

incident in September 2015. The resident was observed with difficulties by RN #100 in the dining room. The resident was treated, and ambulance was called and the resident was transferred to the hospital.

Record review revealed the resident passed away 19 days later.

Interview with Assistant Administrator revealed that hospital discharge summary, recommendations and all progress notes are part of the resident's plan of care. In the above mentioned situations, the plan of care was not provided because the resident was not assessed by an identified health care provider as recommended by the hospital and by the RD as indicated in the progress notes.

The severity of the non-compliance and the severity of the harm was actual as subsequent to the above mentioned situation the resident passed away.

The scope of the non-compliance was isolated to Resident #001.

A review of the Compliance History revealed the following non-compliances related to the Long-Term Care Homes Act, 2007, s. 6. (7). plan of care:

A Written Notification (WN) and a Voluntary Plan of Correction (VPC) was previously issued for s. 6. (7), during inspections:
#2014_159178_0027 dated October 23, 2014,
#2014_159178_0011 dated April 8, 2014,
#2014_241502_0001, dated January 14, 2014,
#2013_109153_0027, dated November 19, 2013,
#013_235507_0001, dated October 1, 2013,
#2013_103193_0008, dated May 27, 2013,
#2013_103193_0002, dated March 19, 2013, and
#2013_108110_0001, dated January 14, 2013.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 27th day of April, 2016

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NITAL SHETH (500)
Inspection No. / No de l'inspection :	2016_413500_0003
Log No. / Registre no:	024756-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 7, 2016
Licensee / Titulaire de permis :	City of Toronto 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 City of Toronto, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with s. 6 (7) to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The plan shall provide the following:

-an outline of the home's immediate, short-term and long-term strategies to educate staff on the importance of the plan of care and risks associated with not providing care as specified in the plan of care.

-a process that ensures staff review the plan of care on readmissions, implement and communicate the plan of care with the interdisciplinary team.

- an outline of how the licensee will ensure that the interdisciplinary assessments are conducted by various disciplines especially and a Registered Dietitian (RD) as required by the plan of care.

- an outline of how the licensee will review the home's procedure for communication with interdisciplinary services and RD, and ensure staff are aware of the procedure and are able to follow it.

The plan shall be submitted by April 22, 2016, via email to nital.sheth@ontario.ca

Grounds / Motifs :

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

A review of resident #001's care plan revealed that the resident was at moderate nutritional risk. The goal indicated that the resident received food and fluid based on medical nutrition requirements and texture that can be chewed and swallowed safely. Staff to monitor the resident's ability to feed self and ensure eating strategies are followed as per the care plan. Check for an identified condition and follow the identified condition care plan as applicable.

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#2013_103193_0008, dated May 27, 2013,
#2013_103193_0002, dated March 19, 2013, and
#2013_108110_0001, dated January 14, 2013. (500)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 10, 2016

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de sions de longue durée
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
Inspection de sions de longue durée
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 7th day of April, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Nital Sheth

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