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 soins 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
Jun 7, 2017	2017_324535_0005	006639-17	Complaint

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

VERON ASH (535)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 5, 6,7,11,12,13,18,19, 2017.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nurse Manager, Nurse Practitioner (NP), Resident Assessment Instrument (RAI) coordinator, Infection and Prevention and Control Lead, registered nursing staff, personal care associates (PCAs), and the resident.

During the course of the inspection, the inspector(s) conducted observations of staff and resident interactions, provision of care, medication practices, infection prevention and control practices, reviewed clinical health records, relevant committee meetings minutes, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **4 VPC(s)**
- **0 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

The MOH received an indentified complaint on an identified date from a complainant regarding 'as needed' medications for a resident.
Record review revealed that the resident had 'as needed' (PRN) over the counter and controlled substance medications ordered and transcribed by the Pharmacy to be administered. During interviews with three registered staff, each staff stated that when the PRN medication was ordered, and that each registered staff interpreted the actual time for administration differently versus when the medication was ordered with a given time interval specified.

During an interview, the resident stated that he/she sometimes requested medication, however he/she was told by the registered staff that it was too early to receive the next dose. The resident also stated that he/she would have to wait for long periods to receive the next dose of medication. During an interview, the registered staff acknowledged that sometimes he/she would inform residents' to wait until the next shift before they could receive the next dose of medication because the maximum of two or three doses ordered were already administered within 24 hours.

During an interview, Nurse Manager stated that the expectation was for registered staff to ensure that the frequency of PRN medication was indicated by the frequency in hours on the physician order form prior to sending the written order to the Pharmacy; and if required the registered staff should clarify the order with the Physician or Nurse Practitioner so that the written plan of care provides clear directions to all registered staff. [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 were integrated, consistent with and complement each other.

The MOH received and identified complaint on an identified date from a complainant regarding a treatment.
A review of the resident's clinical records identified the resident with altered skin integrity. The records indicated that on an identified date, an order was written by the Nurse Practitioner to apply an identified treatment. On an identified date, the Nurse Practitioner wrote an order to discontinue the previous treatment. However, during interviews, two registered staff stated that they continued with the treatment as ordered because they were unaware that the treatment was discontinued. The records showed that the staff continued to use the special treatment for approximately 13 days after the order was discontinued.

Furthermore, both registered staff confirmed that the resident preferred to have the treatment at night to support movement in bed. During interviews, the Nurse Manager and Nurse Practitioner both acknowledged that the xpectation was for registered staff to discontinue the use of the treatment as ordered on an identified date; and that staff collaborate with the team to ensure consistent treatment. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set

out in the plan has not been effective.

The MOH received an identified complaint on an identified date from a complainant regarding refusal of care and treatment.
Record review revealed that the resident frequently refused care that was being offered by various members of the interdisciplinary team since admission to the home on an identified date. The resident refused to have identified care and treatments monitored by the registered staff, refused to purchase proper care devices, and refused the advise of the interdisciplinary team on occasion. During an interview with the resident, he/she confirmed the same information.

During interviews, the Nurse Manager and the Nurse Practitioner confirmed that they were not aware of all the resident's refusal of care and treatment. The Nurse Manager further stated that the expectation was for staff to document each time the resident refusal of care and treatments, and report each episode to the appropriate member of the interdisciplinary team to ensure reassessed and effective treatment when the plan has not been effective. [s. 6. (10) (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 plan of care set out clear directions to staff and others who provide direct care to the resident;
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 were integrated, consistent with and complement each other; and
to ensure that the plan of care was reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: 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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

The MOH received an identified complaint on an identified date from a complainant regarding the lack of assessment and documentation.
Record review revealed that the resident was admitted to the home on an identified date. The resident had treatment for his/her diagnosis prior to admission to the home; and his/her diagnosis was documented by the Nurse Practitioner on an identified date. The information was also confirmed by the registered staff during an interview.

The records also revealed that on another identified date, an assessment was completed by the registered staff; and during an interview, the resident stated that he/she noticed the diagnostic condition but was unsure what had happened.

During an interview, the registered staff, on an identified date, completed a treatment and procedure for the resident. This information was confirmed by documentation in the progress notes on the same date. During an interview, the registered staff also confirmed

that he/she did not complete the specific assessment record for the diagnosed condition. On an identified date, the notes indicated that there was no further documentation or monitoring of the diagnosed condition by the registered staff.

During separate interviews, two registered staff confirmed that they entered the resident's room on an identified date and observed the resident's skin condition. The weekly assessment record was completed at that time and it described the skin condition in details. The records also showed that an immediate referral was sent to the Nurse Practitioner, Nurse Manager, registered dietitian (RD), and occupational therapist (OT).

During an interview, the nurse manager stated that the expectation was for direct care staff to observe the residents' skin for altered skin integrity and report findings to the registered nurse. As well, registered nurses should consistently monitor and assess residents' with skin conditions using the clinical instrument; and document using the clinically appropriate records that was designed for that specific purpose. [s. 50. (2) (b) (i)]

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

The MOH received an identified complaint on an identified date from a complainant regarding the completion of weekly wound assessment using a clinically appropriate assessment tool.
Record review revealed that a resident was admitted to the home on an identified date. The resident had a diagnosis and his/her admission examination indicated that the resident had a diagnosed condition which required weekly treatment. This information was confirmed by a registered staff during an interview. The records also showed that subsequently, the resident developed another condition.

Record review and interviews with three registered staff confirmed that weekly assessment records were not completed and documented on two identified dates. And that the weekly assessment records were not completed and documented on two other identified dates related to another skin condition.

During an interview, the Nurse Manager stated that the expectation was for staff to consistently complete the weekly ulcer/wound clinical assessments tools and report

significant changes by making referral to the appropriate team members as prompted by the document, and as needed. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment; and
to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff when clinically indicated, to be implemented voluntarily.

WN #3: 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 remained in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to the resident or destroyed.

The MOH received an identified complaint on an identified date from a complainant regarding medication management.
A resident was assessed by the home's Resident Assessment Instrument (RAI) to be an independent decision-maker regarding his/her own care and treatment. On an identified date, the inspector observed medication were removed from their original labelled packaging provided by the pharmacy service provider, and placed in a small medication administration container. These medications were left unattended and unsupervised in the dining room area. During an interview, the registered staff stated that he/she saw the medications, but did not remove them because the resident would be returning to take them. During an interview, the nurse manager confirmed that the expectation was that staff do not pre-pour medications and leave them unattended for residents to take at a later time because registered staff must immediately sign that the medications were administered to the resident. [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 remained in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to the resident or destroyed, to be implemented voluntarily.

WN #4: 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:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff were provided training in skin and wound care.

The MOH received an identified complaint on an identified date from a complainant regarding skin and wound care.
A review of the home's training records revealed that only 77% of direct care staff completed the Skin and Wound: Assessment and Healing training program; and only 88% of direct care staff completed the Skin and Wound Training. During an interview, the Nurse Manager confirmed the same information. [s. 221. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all direct care staff were provided training in skin and wound care, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident plan of care related to pain management was based on an interdisciplinary assessment with respect to the resident's health conditions.

The MOH received an identified complaint on an identified date from a complainant regarding pain management and assessment.
Record review revealed that the resident's plan of care did not include a pain assessment upon admission to the home on an identified date; and a pain assessment was not completed when the resident started experiencing pain following discharge from hospital. The records also showed that the resident was being administered over the counter medications and controlled substances as ordered by the physician for pain control. A review of the resident's care plan revealed that the pain was added as a focus on an identified date, after the resident was discharged from hospital although the he/she was being administered the medication for pain since admission to the home.

Interviews with two registered staff confirmed that the resident should have had an admission, quarterly and change of status pain assessments completed; and that there should have been a pain focus included in the written care plan since admission since he/she was being administered pain medication. During an interview, the Nurse Manager stated that the expectation was for registered staff ensure that resident's received pain assessments as appropriate; and that the resident's pain management was based on an interdisciplinary assessment with respect to the resident's health conditions. [s. 26. (3) 10.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident

under the skin and wound care program including assessments, reassessments, interventions and the resident’s responses to interventions were documented.

The MOH received an identified complaint on an identified date from a complainant regarding documentation of care and treatment.
Record review showed that the resident's treatment and assessment records (TAR) were not signed by the registered staff on multiple shifts. A review of the records also showed that on an identified date, a treatment was ordered to be applied to a special areas on the body; however the TAR was signed by registered staff on some dates and some dates indicated ‘2’ meaning that the resident refused the treatment, and ‘7’ meaning the resident was sleeping.

During separate interviews, three registered staff confirmed that the TAR should have been signed consistently to indicate that the treatment was completed; and that the on an identified date, the order should have had corresponding documentation in the notes to support the refusal codes on the TAR.

Record review also showed that on another identified date a special treatment was ordered for use on shower days as ordered by the Nurse Practitioner; however the records showed that although the order was transferred to the TAR, the TAR was left blank without any registered staff signature.

During an interview, the Nurse Manager stated that the expectation was that registered staff sign on all residents' TAR items once treatment was completed, and that staff document in the progress notes and report resident’ refusal of care and treatment so that the appropriate team member could follow up. [s. 30. (2)]

2. The MOH received and identified complaint on an identified date from a complainant regarding documentation and refusal of care and treatment.
During an interview, the resident stated that he/she missed the last four scheduled treatments. Record review and staff interviews confirmed that the resident received one scheduled treatment, and refused two treatments, and the other treatments was provided one day earlier than scheduled.

During an interview, the primary care provider stated that the resident usually accepted his/her treatment; however when the resident has an appointment on the scheduled treatment days, he/she usually refused the treatment. According to the PCA, he/she reported the resident’s refusal of treatment to the registered staff. During an interview,

the registered staff confirmed that the missed treatments list by identified dates, were not documented although he/she was informed by the PCA. The registered staff also stated that the resident was not offered an alternate date to receive the scheduled treatment.

During an interview, the Nurse Manager stated that the expectation was for staff to inform the registered staff when residents' refused their treatment; and the registered staff should visit the resident to discuss the reason for the refusal and document the resident's response. [s. 30. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs were stored were kept locked at all times, when not in use.

The MOH received an identified complaint on an identified date from a complainant regarding safe storage of medication.
A resident was assessed using the home's Resident Assessment Instrument to be an independent decision-maker for his/her own care and treatment. Record review revealed that the resident was assessed and deemed capable to administer his/her own medications. On an identified date, the inspector observed that the resident kept his/her medication in a location in the room. Although the location had a lock in place, the location was kept unlocked. During an interview, the resident informed the inspector that he/she did not have any reason to lock the medication away since nobody would take them. During an interview, the registered staff confirmed that the location was left unlocked.

During an interview, the Nurse Manager confirmed that the resident did not have a key for the location in the room; and that he/she should have been provided a key to ensure safe storage of medications. [s. 130. 1.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

The MOH received an identified complaint on an identified date from a complainant regarding care and treatment issues in the home.
Record review revealed that on an identified date the Nurse Practitioner (NP) wrote an order the initiation of a special procedure related to the resident's condition. The NP also requested that staff notify the lead of the program involved with the same information regarding the special procedure. On an identified date for an extended period, the inspector observed that the resident did not have the special procedure in place related to his/her condition.

During an interview, the registered staff reviewed the NP order and confirmed that the resident should have had the special procedure completed. During an interview, the lead for the program involved confirmed that he/she was not notified at the time the order was written; and that the expectations were for all staff to follow the NP order and program policy and ensure staff and visitors were educated related to the resident's special procedure. [s. 229. (4)]

Issued on this 21st day of June, 2017

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

Original report signed by the inspector.