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
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 11, 2018	2018_420643_0004	004715-18	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

ADAM DICKEY (643)

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): March 19 - 23, 2018.

The following critical incident intake was inspected during this Critical Incident System (CIS) inspection:
Log #004715-18; CIS #M510-000009-18 - related to falls prevention and management and safe transferring and positioning techniques.

Inspector Rebecca Leung #726 attended this inspection during orientation.

During the course of the inspection, the inspector(s) spoke with the Administrator, Nurse Manager (NM), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Care Assistants (PCA), residents and Substitute Decision Makers (SDM).

During the course of the inspection, the inspector(s) conducted observations of staff and resident interactions and the provision of care, record review of health records, staff training records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring techniques when assisting residents.

A Critical Incident System Report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date, related to an incident resulting in

resident #001 sustaining specified injuries. Review of the CIS report revealed that resident #001 had a fall one week prior, with no injury identified at the time. Resident #001 was reassessed the day following the fall, and sent to the hospital for further assessment. Review of Spills Action Centre (SAC) MOHLTC Incident report from the day prior to the submission of the CIS, revealed resident #001 returned from hospital that day with specified injuries.

Review of resident #001's health records revealed that they were admitted to the home with identified medical diagnoses. Review of resident #001's current written care plan revealed they required two person assistance with transferring using a specified transferring device and sling type.

Observation by the inspector revealed resident #001 had an identified transferring device in their room, and an identified sling type which was labeled with resident #001's name and room number. In an interview, resident #001 stated they did not remember the incident in which they sustained the injuries.

Review of resident #001's progress notes revealed that on an identified date, they were being transferred to bed using a transferring device with two staff and slid in the sling. The progress note indicated staff were able to catch resident #001 who later complained of pain. Progress note from the following day revealed the resident complained of pain and showed signs of injury. The physician was called who ordered the resident to be sent to the hospital for assessment. Resident #001 returned to the home five days later, with diagnoses of specified injuries.

In an interview, PCA #104 stated they had been called by PCA #109 to assist them with transferring resident #001 to bed on an identified date. PCA #104 stated they had entered the room and the sling had already been in place for resident #001 and PCA #109 operated the transferring device. PCA #104 stated that resident #001 slid from the sling and they were able to catch resident #001 before falling and with assistance from PCA #109 moved the resident onto their bed. PCA #104 demonstrated to the inspector the manner in which the sling was applied to resident #001 which did not cross the straps of the sling across the top of the resident legs, instead had the resident sitting on top of the sling without the straps crossing over the legs. PCA #104 stated they did not note resident #001 striking any surfaces or objects.

In an interview, PCA #109 stated that PCA #104 assisted them with transferring resident #001 on the above mentioned identified date. PCA #109 stated that when transferring

resident #001 the sling was not properly applied in a criss-cross pattern over the resident's legs. PCA #109 stated that resident #001 was being transferred to bed and quickly slid from the sling when PCA #104 was able to catch the resident and assisted them in moving the resident to the bed. PCA #109 did not recall noting resident #001 striking any surfaces or objects when being transferred.

In an interview, RPN #102 stated that PCA #104 reported to them that there was an incident in which resident #001 was being transferred to bed and slipped from the sling. RPN #102 further stated that they did not consider this incident to be a fall as the PCA stated the resident was caught did not land on a surface. RPN #102 stated they had assessed resident #001's vital signs, did a head to toe assessment, and administered pain medication as resident #001 complained of pain. RPN #102 stated they did not assess the resident for range of motion as they had not considered this to be a fall incident based on PCA #104's report.

In an interview, RN #105 stated that PCA #104 had reported to RPN #102 that resident #001 almost had a fall slipping from the sling. RN #105 stated that resident #001 had complained of pain after the incident. RN #105 stated that they had assessed visually for fracture but did not assess range of motion for resident #001.

Observation by the inspector on an identified date revealed PCA #100 and PCA #101 transferred resident #001 from wheelchair to bed. During the transfer the inspector observed the sling was not applied in a criss-cross pattern over the resident's legs. The right side of the sling was hooked onto the right side of the transferring device, with the left side of the sling hooked on to the left side of the transferring device.

Review of the home's policy titled Sling Selection and Application, policy number RC-0522-17, published January 11, 2014 revealed that application of the identified sling type should follow the conventional bridge type adjustment with the leg straps crossed diagonally in front of the resident and attach to the opposite hook.

In an interview, Nurse Manager (NM) #103 stated that PCAs #104 and #109 were interviewed and had shown the NM how the sling was applied for resident #001's transfer. NM #103 indicated that the resident was on top of the leg straps and the left side of the sling was not hooked to the right side of the transferring device and right side of the sling was not hooked to the left side of the transferring device as per the home's policy. NM #103 acknowledged that PCAs #104 and #109 did not use safe transferring techniques when assisting resident #001 with transferring on the date of the incident. NM

#103 acknowledged that PCAs #100 and #101 did not use safe transferring techniques when assisting resident #001 as observed by the inspector during the inspection. [s. 36.]

Additional Required Actions:

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

WN #2: 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 has failed to ensure that when a resident has fallen, the resident was assessed and where the condition or circumstances of the resident required, a post fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A CIS was submitted to the MOHLTC on an identified date, related to an incident resulting in resident #001 sustaining specified injuries. Review of the CIS report revealed that resident #001 had a fall one week prior, with no injury identified at the time. Resident #001 was reassessed the day following the fall, and sent to the hospital for further assessment. Review of SAC MOHLTC Incident report from the day prior to the submission of the CIS, revealed resident #001 returned from hospital that day with specified injuries.

Review of resident #001's health records revealed that they were admitted to the home with identified medical diagnoses. Review of resident #001's current written care plan revealed they required two person assistance with transferring using a specified transferring device and sling type.

Review of resident #001's progress notes revealed that on an identified date, they were being transferred to bed using a transferring device with two staff and slid in the sling. The progress note indicated staff were able to catch resident #001 who later complained of pain and showed signs of injury. Progress note from the following day, revealed the resident complained of pain. The physician was called who ordered the resident to be sent to the hospital for assessment. Resident #001 returned to the home five days later, with diagnoses of specified injuries.

Review of resident #001's health records failed to reveal a post fall assessment huddle for the fall incident on the above mentioned identified date.

Review of the home's policy titled Falls Prevention and Management, policy #RC-0518-21, published January 10, 2016, revealed a fall is defined by the Canadian Institute for Health Information (CIHI) as any unintentional change in position where the resident ends up on the floor, ground or other lower level. The policy indicates that a "Post Fall Assessment Huddle" shall be completed after each fall prior to the end of shift. A post fall assessment huddle meeting is to be held with the interdisciplinary team on unit to identify root cause and preventative strategies for fall and injury prevention and documented on the post fall assessment huddle form.

In an interview, RPN #102 stated that when a resident has a fall, an incident report should be completed as well as a post fall huddle assessment. RPN #102 stated that it was reported to them by PCA #104 that resident #001 slid from the sling and was caught and didn't do a post fall assessment huddle because PCA #104 said they did not fall. RPN #102 stated that the home's definition of a fall is a shift in position to floor or any other position and is unintentional would be considered a fall.

In an interview RN #105 stated that when a resident has a fall, the protocol in the home is to complete a post fall huddle form, and have a meeting to discuss what happened and things that can be done. RN #105 stated that a near miss would be considered a fall by the home and a post fall huddle would be completed.

In an interview, NM #103 stated the definition of a fall in the home was any unintentional change in level of a resident from higher to lower level no matter where that is would be considered a fall using the CIHI definition. NM #103 stated that the tool used to assess a resident after a fall is the post fall huddle assessment. NM #103 stated that a near miss is considered a fall and if a resident begins to fall and is caught that would be a considered a fall and has impact on the resident. NM #103 indicated that a post fall

huddle assessment would be expected to have been completed in the case of resident #001's fall incident on the above mentioned identified date. NM #103 acknowledged that when resident #001 had fallen the licensee failed to ensure that a post fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (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 when a resident has fallen, the resident is assessed and 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, to be implemented voluntarily.

Issued on this 12th day of April, 2018

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 soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ADAM DICKEY (643)
Inspection No. / No de l'inspection :	2018_420643_0004
Log No. / No de registre :	004715-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 11, 2018
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 :	Nelson Ribeiro

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 :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 36.

Specifically, the licensee must:
1) Ensure that for resident #001 and all other residents who require assistance with transferring with a mechanical lift; staff use safe transferring techniques to assist the resident.
2) Develop an auditing system in the home to ensure staff are assisting residents with transferring using safe techniques according to the home's written policies.
3) Maintain a written record of audits conducted of transferring techniques in the home. The written record must include the date and location of the audit, the resident's name, staff members audited, equipment utilized, the name of the person completing the audit and the outcome of the audit.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring techniques when assisting residents.

A Critical Incident System Report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date, related to an incident resulting in resident #001 sustaining specified injuries. Review of the CIS report revealed that resident #001 had a fall one week prior, with no injury identified at the time. Resident #001 was reassessed the day following the fall, and sent to the hospital for further assessment. Review of Spills Action Centre (SAC) MOHLTC Incident report from the day prior to the submission of the CIS, revealed resident #001 returned from hospital that day with specified injuries.

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Observation by the inspector revealed resident #001 had an identified transferring device in their room, and an identified sling type which was labeled with resident #001's name and room number. In an interview, resident #001 stated they did not remember the incident in which they sustained the injuries.

Review of resident #001's progress notes revealed that on an identified date, they were being transferred to bed using a transferring device with two staff and slid in the sling. The progress note indicated staff were able to catch resident #001 who later complained of pain. Progress note from the following day revealed the resident complained of pain and showed signs of injury. The physician was called who ordered the resident to be sent to the hospital for assessment. Resident #001 returned to the home five days later, with diagnoses of specified injuries.

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The severity of this issue was determined to be a level 3 as there was actual harm to resident #001. The scope of this issue was a level 1 as it related to one of three residents reviewed. The home had a level 4 compliance history as they had ongoing noncompliance with O. Reg. 79/10, s. 36. that included:
- compliance order CO #001 issued June 17, 2017, with a compliance due date of July 11, 2017 (2017_635600_0008).
(643)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 28, 2018

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 11th day of April, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Adam Dickey

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