Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
55 St. Clair Avenue West, 8th Floor
Toronto ON M4V 2Y7

Telephone: 416-325-9297
1-866-311-8002

Facsimile: 416-327-4486

Bureau régional de services de Toronto
55, avenue St. Clair Ouest, 8iém étage
Toronto, ON M4V 2Y7

Téléphone: 416-325-9297
1-866-311-8002

Télécopieur: 416-327-4486

☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
April 5,6,7,8,12,13,14, 2011	2011_162_9510_05Apr121248 2011_174_9510_06Apr105958	Critical Incident M510-000024-11 Log # T-849

Licensee/Titulaire
Toronto Long-Term Care Homes and Services,
55 John Street, 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/Nom de l'inspecteur

Nancy Bailey #174, Marsha Hardwick #125, Tiina Tralman, #162

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct an inspection of a CIS report regarding abuse.

During the course of the inspection, the inspectors spoke with:

- Administrator
- Assistant Administrator
- Director of Care
- Head Nurse
- Registered staff
- Personal Care Aides
- Resident's Power of Attorney
- Educator

During the course of the inspection, the inspectors:

- Reviewed resident health record,
- Inspected resident room,
- Reviewed Policies: Residents' Bill of Rights; Zero Tolerance for Abuse and Neglect; Resident Abuse and Neglect: Investigation and Reporting & Education and Awareness on Prevention of Resident Abuse, Police Reference Checks, Ministry of Health and Long-Term Care Mandatory and Critical Incident Reporting Requirements.
- Reviewed inservice education program provided to staff related to Licensee policies: Residents' Bill of Rights; Zero Tolerance for Abuse and Neglect; Resident Abuse and Neglect: Investigation and Reporting & Education and Awareness on Prevention of Resident Abuse, Ministry of Health and Long-Term Care Mandatory and Critical Incident Reporting Requirements.

The following Inspection Protocols were used in part or in whole during this inspection: Prevention of Abuse and Neglect Inspection Protocol

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
1 VPC
2 CO: CO # 001, #002

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007 s. 19. (1). Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings:

1. The licensee failed to protect an identified resident from abuse.
2. The licensee failed to comply with the policy entitled "Zero Tolerance for Abuse and Neglect (RC-0305-00)" which states The Long Term Care Homes and Services Division strictly adheres to and enforces zero tolerance of abuse and neglect of residents.
3. A staff member was found on an unassigned unit. There was no other staff to care for those residents on the assigned unit. At least one of the residents was deemed high risk with unpredictable behaviours and a tendency to wander off the unit at night.
4. Staff members stated a staff member returned late from breaks, and would be absent from the assigned unit without explanation.

Inspector ID #:	125, 162, 174

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Orders of the Inspector" form.

WN #2: The Licensee has failed to comply with O. Reg 79/10, s. 101. (1) 1, 3. Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

Findings:

1. The licensee did not investigate a written complaint
2. Administrator confirmed receipt received receipt of the identified written complaint.
3. There was no response to the complainant in respect to this complaint.

Inspector ID #:	125, 162, 174

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Orders of the Inspector" form.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007 s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings:

1. The licensee did not immediately forward to the Director a written complaint.

Inspector ID #:	125, 162, 174

Additional Required Actions:

VPC - pursuant to the *Licensees 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 the licensee who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. Irina Valman Marsha Hardwick Nancy A Bailey
Title: Date:	Date of Report: (if different from date(s) of inspection). June 1, 2011

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Orders of the Inspector

Pursuant to section 153 and/or section 154 of the
Long-Term Care Homes Act, 2007, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire		☒ Public Copy/Copie Public
Name of Inspector:	Nancy Bailey, Marsha Hardwick, Tiina Tralman	**Inspector ID #**	174, 125, 162
Log #:	T-849		
Inspection Report #:	2011_162_9510_05Apr121248 2011_174_9510_06Apr105958		
Type of Inspection:	Critical Incident M510-000024-11		
Date of Inspection:	April 5,6,7,8,12,13,14, 2011		
Licensee:	Toronto Long-Term Care Homes and Services, 55 John Street, Toronto, ON M5V 3C6		
LTC Home:	Castleview Wychwood Towers, 351 Christie Street, Toronto, ON M6G 3C3		
Name of Administrator:	Vija Mallia, Administrator		

To Toronto Long-Term Care Homes and Services, you are hereby required to comply with the following order by the date set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(b)

Pursuant to: LTCHA, 2007 S.O. 2007 s. 19. (1). Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order:

The licensee shall prepare and submit a written plan by Friday, May 27, 2011 to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected

by the licensee or staff. 2007, c. 8, s. 19 (1).

This plan shall be implemented Friday, May 27, 2011.
The plan is to be submitted to Inspector: Tiina Tralman, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 55 St. Clair Avenue West, Toronto, ON M4V 2Y7
Fax 416-327-4486.

Grounds:

1. The licensee failed to protect an identified resident from abuse.

2. The licensee failed to comply with the policy entitled "Zero Tolerance for Abuse and Neglect (RC-0305-00)" which states The Long Term Care Homes and Services Division strictly adheres to and enforces zero tolerance of abuse and neglect of residents.

3. A staff member was found on an unassigned unit. There was no other staff to care for those residents on the assigned unit. At least one of the residents was deemed high risk with unpredictable behaviours and a tendency to wander off the unit at night.

4. Staff members stated a staff member returned late from breaks, and would be absent from the assigned unit without explanation.

This order must be complied with by:	Friday, May 27, 2011		
Order #:	002	**Order Type:**	Compliance Order, Section 153 (1)(b)

Pursuant to: O. Reg 79/10, s. 101. (1) 1, 3. Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint,
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

Order:

The licensee shall prepare and submit a written plan by Friday, May 27, 2011 to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a

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Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
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resident or operation of the home is investigated and resolved if possible and provide the appropriate response in accordance with O. Reg. 79/10, s 101.

This plan shall be implemented Friday, May 27, 2011.
The plan is to be submitted to Inspector: Tiina Tralman, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 55 St. Clair Avenue West, Toronto, ON M4V 2Y7
Fax 416-327-4486.

Grounds:

1. The licensee did not investigate a written complaint
2. Administrator confirmed receipt received receipt of the identified written complaint.
3. There was no response to the complainant indicating in respect to this complaint.

This order must be complied with by:	Friday, May 27, 2011

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 service for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
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 group of members not

connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Issued on this 16th day of May, 2011.	
Signature of Inspector:	Tiina Tralman, Marsha Hardwick, Nancy A Bailey
Name of Inspector:	Nancy Bailey, Marsha Hardwick, Tiina Tralman
Service Area Office:	Toronto Service Area Office