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
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☐ 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 21, 26, 27, 28, 2011	2011_162_9510_19Apr083530	Complaint Log # T-092

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

Tiina Tralman, #162, Monica Klein #193

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection regarding abuse.

During the course of the inspection, the inspectors spoke with:
- Administrator, Director of Care, Nurse Manager, Registered staff, Personal Care Aides, Educator, Behavioural Support Nurse, Family members.

During the course of the inspection, the inspectors:
- Reviewed residents' health records.
- 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, 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.
- Reviewed licensee responsive behaviour program.

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

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

3 WN, 2 VPC

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 O. Reg 79/10, s. 134 (a) Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

Findings:

1. There was no monitoring and documentation of the effectiveness of the drug and resident's response after change in medication order for an identified resident.

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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 when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O. Reg. 79/10, s. 8 (1)(a)(b). 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 all applicable requirements under the Act; and

(b) is complied with.

Findings:

According to O. Reg. 79/10, s. 114 (1) the licensee ensured that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

1. The licensee did not comply with their Policy 8-1 entitled "Medication Administration Record" (MAR) that states "chart all medications administered by signing your initials in the appropriate box corresponding to correct medication, date, and time on the MAR sheet when the registered staff signed on the MAR as an identified resident being administered medication twice when in fact it was only administered once.

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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 that the plan, policy, protocol, procedure, strategy or system, (a) is in compliance with and is implemented in accordance with all applicable requirements under the Act; and (b) is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O. Reg 79/10, s. 107 (3) 4. The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital.

Findings:

1. The licensee did not inform the Director of an incident in the home, when a resident sustained an injury followed by transfer to the hospital, no later than one business day after the occurrence of the incident, followed by a report. The Ministry of Health Critical Incident System (CIS) was reviewed and no Critical Incident was received from the licensee reporting that the identified resident was transferred to hospital because of an unexplained injury.

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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. Jiva Halman
Title: Date:	Date of Report: (if different from date(s) of inspection).