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 prévue 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 23, 2019	2019_804600_0020	012007-19, 013056-19, 014106-19	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 365 Bloor Street East, 15th Floor TORONTO ON M4W 3L4

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

GORDANA KRSTEVSKA (600)

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): September 10, 11, 12, 13, 16, 17, 2019. Off site September 20 and 23, 2019.

The following intakes were completed in this Critical Incident System Inspection:
CIS #M510-000025-19, log #012007 and CIS #M510-000027-19, log #013056-19, related to falls prevention,
CIS #M510-000031-19, log #014106-19, related to alleged staff to resident physical abuse.

Note: A non-compliance related to LTCHA, 2007, 79/10, s. 6. (11) (b) identified in a concurrent inspection #2019_804600_0019 (log #016962-19), was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing (DON), Nurse Managers (NMs), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Personal Care Aids (PCA), Housekeeping staff, Behavioural Support of Ontario (BSO)Team Staff, and residents.

During the course of the inspection, the inspectors conducted observations of the home including resident home areas, the provision of resident's care, resident and staff interactions, reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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	Légende 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. (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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #003 so that their assessments were integrated, consistent with and complemented each other.

A Critical Incident System (CIS) report was submitted to the Ministry of Long Term care (MLTC) on an identified date regarding alleged staff to resident physical abuse, identified by the home after the management was visited by the police who came to the home on request by a family member.

A review of resident #003's health record, home's investigation and interviews with staff indicated that on an identified date resident #003 sustained a skin alteration on their identified body part. During the process of an activity of daily living, an identified object caused an altered skin integrity. The family was notified, and no concerns were identified. On a specified date, the family member came in to visit the resident and noted the resident's skin alteration on the identified body part, had changed. The family member reported to the Acting Nurse Manager (NM) at that time #108 and Director of Nursing (DON) #109 regarding the change of skin alteration. The home discussed starting an investigation the following week. However, the family contacted the police, that visited the home on a specified date. The home submitted the CIS as they

acknowledged the family alleged physical staff to resident abuse. A few days later, the home sent a written response to the family member, informing the family that the home could not find any evidence to substantiate the allegation of abuse.

A review of resident #003's Minimum Data Set (MDS) assessment prior to the incident, from an identified date, indicated the resident had areas of altered skin integrity.

A review of the resident's health record indicated that the resident was on a specified treatment and was identified to be at high risk for alteration in skin integrity.

A review of the resident progress notes indicated that resident #003 sustained a skin alteration on an identified body part from an identified object. Substitute Decision Maker (SDM) was notified, the resident was referred to Medical Doctor (MD) and the protocol for skin alteration was followed. On an identified date Registered Practical Nurse (RPN) #110 documented that they received a lab report indicating an abnormal result and they notified the MD. The MD ordered to hold the specified treatment for a number of days and to perform lab test again in a few days. The RPN also documented that they identified that the skin alteration had worsened and documented "no active change", however there was no documentation to indicate the MD had been notified. In the interview the RPN stated that they were thinking that Registered Nurse (RN) #106 was looking over the resident's skin alteration and they knew how it looked the previous day, so they would communicate to the MD if there was any concern. Further in the progress notes the RPN documented that the resident complained of discomfort but the RPN did not identify visible signs. There was no indication that this was communicated to the RN, but documented in the progress notes the resident would be monitored and endorsed to the next shift. Further review of the progress notes indicated that the staff had not monitored the resident's condition between identified dates.

On a specified date, after the MD assessed the resident, MD's note indicated that they were contacted about change in the health status of resident #003, but they were not informed of the identified acute change of the resident's skin alteration. The MD prescribed a new treatment and documented they might have prescribed some treatment for the changed condition of the altered skin if they were aware on the identified date when they were called.

Two days later after MD's visit, RN #110 documented that the resident's body part had changed. The RN documented also that the resident voiced discomfort despite a gentle approach during the provision of treatment, however, review of the progress notes did

indicate the MD was notified. Further documentation indicated resident #003 exhibited responsive behaviour during care and treatment. The change of the resident's body part worsened and staff continued to monitor the resident. It was at the beginning of the following month when the RN notified the MD about observing resident #003's identified body part had changed status and worsened. A Nurse Practitioner (NP) assessed the resident the next day and ordered a test that came back positive. The resident was prescribed treatments and after a few courses the skin altercation healed at the beginning of the following month.

An interview with Personal Care Aid (PCA) #103 confirmed that on an identified date they provided care to resident #003, they dressed and transferred the resident from bed to a wheelchair and from wheelchair to the toilet. They noted the skin alteration while the resident was on the toilet and notified the RPN.

In an interview, RPN #104 who was notified by the PCA about the skin alteration, confirmed that they worked on the identified date, day shift when PSW #103 reported that resident #003 had some change in the skin integrity. Both the RPN and the PCA saw the identified object that caused altered skin integrity. The RPN indicated that after they saw the skin alteration they endorsed to the "treatment nurse" to do the dressing as per the home's protocol. RPN #104 further stated that they had administered treatment to resident #003 but they were not aware they had to monitor the resident.

An interview with RPN #110 indicated that they worked on a specified date on day shift when they received the lab report and notified the MD. Further the RPN stated they saw the skin alteration when RN #106 was applying the dressing and it was closed. Since this was the first time the RPN had seen the altered skin, they were unaware of whether the skin alteration had changed in size over time. Further the RPN stated, the RN #106 on the floor was there looking at the resident's skin alteration and no comment was made about the change in size of the skin alteration.

In an interview, the RN #106 indicated that the staff worked hard to make sure the resident's skin alteration healed and it took them more than a month with lot of dressings and antibiotics to heal the altered skin. The RN also acknowledged that initially when the resident was injured the staff did not monitor the resident between the evening shift of the identified date to the day shift of few days later. The RN also acknowledged they did not document in the progress notes after the concern had been endorsed by the previous registered staff, and the physician was not notified when the condition of the altered skin had changed on the identified date.

An interview with NM #108 indicated that the MD should have been notified every time the condition of the resident's skin alteration had changed and the staff should monitor and communicate every shift about the progress of the skin alteration. [s. 6. (4)]

2. The licensee has failed to ensure that when the plans of care for resident #004 and resident #002 were being revised because care set out in the plans had not been effective, that different approaches were considered in the revision of the plan of care.

The MLTC received a CIS report on an identified date regarding an incident that happened on an identified date, that caused an injury to resident #004 for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

A review of the resident's clinical record indicated that on a specified date, resident #004 was found on the floor in a common area. The fall was not witnessed. The resident complained of discomfort on an identified body part so the physician was notified and the resident was sent for further assessment and to rule out any injury. The resident's incident report indicated that the resident had few fall incidents in the previous six months, or a couple in the previous 30 days and the assessment indicated the resident was high risk for falls. Predisposing conditions were listed as well. During the post incident assessment it was reiterated to the staff to be aware of the interventions.

A review of the resident's written plan of care last updated on an identified date indicated that the resident had interventions in the plan of care to prevent injury.

An interview with RPN #100 indicated that when a resident has an incident, they enter the date of the incident in the plan of care, but they do not put a new strategy in place, because there are interventions there already. [s. 6. (11) (b)]

3. The MLTC received a CIS report on an identified date for an incident that happened on a specified date, that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

A review of the resident #002's MDS assessment from an identified date indicated that the resident was admitted to the home with an identified health condition. The resident was mobile using an assistive device and they needed assistance by one staff to assist with some of the activities of daily living. They had a fall in the past 31 to 180 days prior

the assessment and no indication of having discomfort; they were on analgesics daily.

A review of the quarterly MDS assessments record from two identified days and the resident's assessment for risk for fall tool indicated that resident #002 was identified to be at risk for falls.

A review of the resident's clinical record for three months indicated resident #002 had five falls up until the record was reviewed.

A review of the resident's progress notes for three months indicated that the resident had falls but no new strategies were implemented.

In an interview, RPN #100 who attended to the resident on the last two incidents, indicated that they completed the post incident assessment and entered the date of the incident in the resident's written plan of care. However, the RPN stated that they were told only to enter information when the resident had a fall but not any new strategies. When asked about the effectiveness of the existing strategies, the RPN stated that they feel the resident needs to be monitored, however, they have not entered this strategy in the resident's written plan of care.

An interview with the NM #101 indicated that the registered staff was expected to do a post fall assessment of the resident when they had a fall and to conduct a post fall huddle, where the staff will identify the reason for the fall, come up with a new strategy to prevent further incidents and enter the new intervention in the resident's written plan of care.

In an interview, the DON acknowledged that when a resident has a fall and is reassessed, the plan of care needs to be revised and new approaches should be considered in the revision of the plan of care. [s. 6. (11) (b)]

4. A complaint was received to the MLTC on n identified date, regarding resident#001's increased incidents and involvement of another resident in the incidents.

A review of the resident's clinical record indicated that the resident had a number of falls in 2018, and additional falls in 2019, up until the record was reviewed.

A review of the resident's written plan of care indicated that resident #001 was identified to be at high risk for falls. Goal set for this resident was to remain free of falls and/or

potential injury related to falls through to the next review date. Interventions set to prevent the falls were notified in the written plan of care.

Further review of the resident's written plan of care indicated that the resident had identified behaviours and the goal set was the resident to remain in a safe and secure environment. Interventions set for this goal were noted in the resident's written plan of care.

The written plan of care was created on an identified date , revision status dated on a specified date, and last updated recently.

A review of the resident's three post fall assessments indicated that regardless of the causes for the falls, the plan of care indicated the same strategies for falls prevention.

In an interview, Registered Practical Nurse (RPN) #100 who attended to the resident on the last two incidents indicated that they completed the post incident assessments and entered the information about the incident in the resident's written plan of care. However, the RPN stated that they were told only to enter information when the resident had a fall but not any new strategies. When asked about the effect of the existing strategies and their continuing to implement them as the resident continued to have falls, the RPN stated that they felt the resident has to be monitored.

An interview with the Nurse Manager (NM) #101 indicated that the registered staff was expected to do post incident assessment of the resident when they had a fall and to conduct a post fall huddle, where the staff will identify the reason for the fall, come up with a new strategy to prevent further incidents and enter the new intervention in the resident's written plan of care.

In an interview, the Director of Nursing (DON) acknowledged that when resident #001 had a fall and was reassessed, the plan of care was revised but no new approaches has been considered in the revision of the plan of care.

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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, to ensure that when the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, that different approaches have been considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) 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. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a verbal complaint made to the licensee or a staff member concerning the care of a resident had been investigated, resolved and response provided within 10 business days of receipt of the complaint, and the complaint that alleged harm or risk of harm to resident #003, had the investigation commenced immediately.

A CIS report was submitted to the MLTC on an identified date regarding alleged staff to resident physical abuse.

A review of resident #003's health record, home's investigation and interviews with staff indicated that on an identified date resident #003 sustained a skin alteration during the process of an activity of daily living. The family was notified, and no concerns were identified. On a specified date, the family member came in to visit the resident and noted the resident's skin alteration on the identified body part, had changed. The family member reported to the Acting Nurse Manager (NM) at that time #108 and Director of Nursing (DON) #109 regarding the change of the skin alteration. The home discussed starting an investigation the following week. However, the family contacted the police, that visited the home on a specified date. The home submitted the CIS as they acknowledged the family alleged physical staff to resident abuse. The home investigation record indicated that the home did not initiate the investigation immediately after they acknowledged the alleged abuse.

In an interview NM #108 acknowledged that they did not start the investigation immediately, they did not remove the staff alleged of physical abuse immediately, nor started the interviews. However, the NM indicated that they had communicated with the SDM during that time, but the correspondence was not documented.

An interview with DON indicated they were not aware that the SDM reported a concern regarding the altered skin integrity and staff involvement, was considered a complaint and did not report until they saw the police in the home on a specified date when they submitted the CIS to the MLTC. [s. 101. (1) 1.]

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 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 investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation is commenced immediately, to be implemented voluntarily.

Issued on this 7th day of November, 2019

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

Original report signed by the inspector.