Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jun 10, 2020	2020_767643_0008	009299-20	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

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): May 22, 25, 27, 29, June 2 and 3, 2020, as an off-site inspection.

The following Critical Incident System (CIS) intake was inspected during this inspection:
Log #009299-20; CIS #M510-000012-20 - related to falls prevention and management.

A complaint inspection (2020_767643_0009, Log #010389-20) was inspected concurrently during this inspection to inspect family concerns related to the above CIS intake.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Nurse Manager - Clinical (NM), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and resident family member(s).

During the course of the inspection the inspector reviewed resident health records, reviewed footage from the home's Closed Circuit Television System (CCTV) and reviewed relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **1 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. (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 resident #001 was reassessed and the plan of care was reviewed and revised when the resident's care needs changed.

A Critical Incident System (CIS) report was submitted to the Director for an incident in which resident #001 was sent to hospital and resulted in a significant change in condition. According to the CIS report, resident #001 had a fall incident on an identified date. Resident #001 had an x-ray performed in the facility, results of which showed a specified injury for which the resident was sent to hospital for treatment.

Review of resident #001's Minimum Data Set (MDS) assessment with reference date approximately two weeks prior to the fall incident, showed the resident did not walk in the room or corridor during the observation period. The MDS assessment further showed resident #001 was dependent on staff for locomotion with a specified mobility device.

In interviews, PSWs #103 and #104 indicated that resident #001 had been exhibiting an identified behavior while using the above specified mobility device in common areas, which required the staff to reposition the resident and at times, use an identified function on the mobility device to manage the behavior. In interviews, RPNs #105 and #106 indicated that they were aware of the behavior exhibited by resident #001 for some time, and indicated the above interventions would be used by staff to minimize the resident risk of falling. Staff members #103, #104, #105 and #106 indicated resident #001 would usually be in the common area of the unit where staff could monitor them and utilize the above intervention to minimize the fall risk.

Review of resident #001's care plan at the time of the fall incident showed they were dependent on staff using the above specified mobility device for locomotion around the room or unit. The care plan did not contain information related to the resident's identified behavior when using the specified mobility device, nor interventions to minimize the risk of falling due to the identified behavior.

In interviews, PT #108 and DOC #102 indicated that the behavior exhibited by resident #001 while using the specified mobility device constituted a potential fall risk. PT #108 and DOC #102 indicated that an intervention should have been included in resident #001's care plan which directed staff to reposition the resident and use an identified function on the mobility device for comfort and prevention of falls.

In an interview, Nurse Manager – Clinical (NM) #102 indicated that they were aware of the identified behavior exhibited by resident #001 while using the specified mobility device for some time, requiring repositioning and use of the identified function on the mobility device to minimize risk of falling. NM #102 indicated that the resident began exhibiting this behavior following the resident becoming non-ambulatory due to progression of their disease process. NM #102 indicated that this information should have been included in resident #001's plan of care to direct staff to monitor the resident and reposition and use the identified function on the mobility device as needed to minimize the risk of falling due to the identified behavior. NM #102 acknowledged that resident #001's care plan had not been revised following a change in the resident's care needs related to dependency on the above mentioned device. s. 6. (10) (b)]

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 with ensuring that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) 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. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that caused an injury to resident #001 for which the resident was taken to the hospital and that resulted in a significant change in the resident’s health condition.

A Critical Incident System (CIS) report was submitted to the Director on an identified date, for an incident in which resident #001 was sent to hospital and resulted in a significant change in condition. According to the CIS report resident #001 had fallen 25 days prior to submission of the CIS report. Resident #001 had an x-ray performed in the facility, results of which showed an identified injury. Resident #001 was sent to hospital the day following the fall incident. The CIS report further indicated that a CIS was originally created three days following resident #001's hospitalization, however was not submitted to the Director.

In an interview, NM #102 indicated that they had initiated and saved the CIS report and sent an e-mail to DOC #101 to review prior to submitting the report to the Director. NM #102 indicated that the staff of the home were aware that resident #001 had a significant change in their condition on the day they were hospitalized, following receipt of the resident’s x-ray report. NM #102 indicated that the incident had not been reported to the after-hours line, nor was the CIS report submitted within the required timelines.

In an interview, DOC #101 indicated NM #102 was new to Long-Term Care and as such wanted to review any CIS reports completed by the NM. The DOC indicated that NM #102 sent an email to the DOC and they reviewed the CIS report for submission. The DOC indicated that NM #102 had saved the CIS report three days following resident #001's hospitalization, but did not click submit to send the CIS report to the Director. The DOC indicated that the CIS report was then re-written and submitted on the above identified date. DOC #101 acknowledged that the incident was not reported to the Director within the required timelines as per the Regulation. [s. 107. (3) 4.]

Issued on this 17th day of June, 2020

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

Original report signed by the inspector.