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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
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Bureau régional de services de Toronto
5700, rue Yonge 5e étage
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 27, 2021	2021_526645_0009	005307-21	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
Seniors Services and Long-Term Care (Union Station) c/o 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(s)/Nom de l'inspecteur ou des inspecteurs

DEREGE GEDA (645)

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 31, April 1 and 6, 2021.

This inspection was completed to inspect upon intake log# 005307-21, for Critical Incident System (CIS) report number M510-000005-21, related to the unexpected death of resident #001.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Nursing (DON), Nurse Manager (NM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspector observed the provision of care, services and supplies; reviewed records including but not limited to relevant training records, video surveillance footage, policies and procedures, residents' clinical health records, and staff schedules.

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

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	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. 19. Duty to protect

Specifically failed to comply with the following:

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/Faits saillants :

1. The licensee has failed to ensure that a resident was not neglected by the licensee or staff.

In accordance with the definition identified in section 2(1) of the Regulation 79/10 “neglect” means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.

A Critical Incident System(CIS) report was submitted to the Ministry of Long-Term Care (MLTC) related to the unexpected death the resident. The report indicated that the resident injured themselves and subsequently passed away.

The resident was admitted to the home a few days prior to the incident. The admission clinical records indicated that the resident had significant history of self-harming behaviours. Review of the home’s admission assessment did not indicate if the home completed the assessments to reduce the risk to the resident. The resident’s admission care plan did not indicate any interventions to mitigate these risks. The family member of the resident also alerted the home about possible self-harm behaviours. There was no assessment completed and no interventions were implemented following receipt of the family concern. A few days later, the resident injured themselves and subsequently passed away.

RN #100 indicated that they completed the admission assessment and received the family concern regarding the risk to the resident. The RN indicated that they were aware of the resident’s history of self harm and illnesses. During the interview, RN #100 indicated that no assessment of the risk to the resident was carried out, nor were interventions to mitigate the risk developed or implemented.

Interviews with NM #101 and DON confirmed that the required assessments were not completed and interventions were not developed. NM #101 indicated that it was the expectation of the College of Nurses of Ontario that registered staff complete the required assessments and implement interventions to promote resident safety.

Sources: resident's admission assessment records, plan of care and progress notes, and interviews with registered staff, NM and the DON. [s. 19. (1)]

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) 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 applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the required written plan to deal with medical emergencies was complied with.

LTCHA s. 87 (1) (a) requires the licensee to ensure that there are emergency plans in place including measures to deal with emergencies. O. Reg. 79/10, s. 230 (2) and s. 230 (4) 1. v. require that the home has a written plan to deal with medical emergencies. Inspector #645 confirmed that the home had a written policy for medical emergencies.

The home's medical emergency policy titled "Code Blue Procedure During COVID-19 Pandemic, #PP-0903-00" last reviewed on May 2020, provided direction to staff members on procedures during a medical emergency. The policy directed staff members to do the following:
- Cardiopulmonary Resuscitation (CPR) is considered a high-risk aerosol generating procedure and all code blue cases should be managed under the assumption that the resident could be affected by COVID-19.
- The home shall have a coordinated approach to respond to medical emergencies and code blue situations.
- Ensure that everyone involved in the CPR process is wearing personal protective equipment (PPE) including N95 mask, gown, face-shield and gloves prior to entering the

physical space of the resident and before initiating CPR.
- Place a towel over the resident’s nose and mouth immediately prior to checking respiration and pulse.
- The second responder to call 911 and obtain the Automated External Defibrillator (AED) to the scene.

Inspector #645 reviewed the video surveillance footage of the home's response to a medical emergency (code blue). The footage showed an uncoordinated code blue response from the staff members. On an identified date, RN #102 and the facility physician were observed entering the resident's room and found a resident unresponsive. A few miniutes later, RN #102 was observed exiting the room, and returned carrying an emergency box containing goggles and suctioning tubes. Then, the same RN brought an Ambu-bag and an oxygen tank. No staff member was observed bringing the emergency defibrillator until paramedics arrived. Throughout the whole emergency process, the staff members did not wear the required N95 masks and gowns as outlined in the policy.

RN #102 indicated that the home's code blue paging system was not working at the time, causing a delay with the emergency process, resulting in uncoordinated code blue response. They indicated that they had to go to a different floor to announce the code blue. Normally, when the emergency code system activated, staff members would bring the necessary equipment in an organized manner including the emergency defibrillator and appropriate PPEs. The RN confirmed that none of the staff members, including the physician, were wearing the necessary PPE during CPR.

Interview with NM #101 indicated that it was the expectation of the home that staff members wear the appropriate PPE during medical emergency, prior to entering the resident’s room and during CPR. The NM confirmed that the emergency defibrillator was not brought during the code and reiterated that staff members are expected to bring the necessary emergency equipment in an organized and timely manner.

Sources: video surveillance footage, the home’s Code Blue policy, and interviews with registered staff, NM and the DON. [s. 8. (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 any policy and procedure the home had, instituted or otherwise put in place is complied with, to be implemented voluntarily.

Issued on this 4th day of June, 2021

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

Original report signed by the inspector.

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) : DEREGE GEDA (645)

Inspection No. / No de l’inspection : 2021_526645_0009

Log No. / No de registre : 005307-21

Type of Inspection / Genre d’inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Apr 27, 2021

Licensee / Titulaire de permis : City of Toronto
Seniors Services and Long-Term Care (Union Station), c/o 55 John Street, 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 : Tim Burns

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To City of Toronto, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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 / Ordre :

The licensee must be compliant with s. 19 (1) of the Long-Term Care Homes Act.
Specifically, the licensee must:

1. Ensure that upon admission to the home, as required by O.Reg. 79/10 s. 24 (4), a 24-hour care plan is developed which is based on an assessment of the resident's needs and preferences, and upon the information provided by the placement coordinator.

2. As required by O.Reg. 79/10 s. 24 (2), include in each resident's 24-hour care plan any risks the resident may pose to themselves, and interventions to mitigate those risks.

3. Conduct a risk assessment, where it is identified that a resident has any identified risk or history of self-harm; to identify any risk to the resident and identify interventions including, but not limited to:
a. a monitoring system to ensure the resident's safety,
b. a safe environment is maintained, including removal of any potentially harmful items, and
c. referral to specialized services where the resident's behavioural support needs exceed the expertise of on-site behavioural interventions.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that a resident was not neglected by the licensee or staff.

In accordance with the definition identified in section 2(1) of the Regulation

79/10 “neglect” means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.

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Interviews with NM #101 and DON confirmed that the required assessments were not completed and interventions were not developed. NM #101 indicated that it was the expectation of the College of Nurses of Ontario that registered staff complete the required assessments and implement interventions to promote resident safety.

Sources: resident's admission assessment records, plan of care and progress notes, and interviews with registered staff, NM and the DON. [s. 19. (1)]

An order was made by taking the following factors into account:
Severity: There was actual harm with this non-compliance the resident

successfully committed suicide.
Scope: The scope of the non-compliance was isolated to resident #001.
Compliance History: There was one or more unrelated non-compliance in the past 36 months.

(645)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 05, 2021

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 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 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) Commission d'appel et de revision des services de santé 151, rue Bloor Ouest, 9e étage Toronto ON M5S 1S4	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère 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 27th day of April, 2021

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Derege Geda

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