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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Amended Public Copy/Copie modifiée 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
Jan 07, 2022	2021_833763_0019 (A1)	008945-21, 010417-21, 012285-21	Complaint

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

Amended by IANA MOLOGUINA (763) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): Sept 24, 28-29, Oct 1, and 4-8, 2021.

The following intakes were completed during this Complaint Inspection:

- Log #012285-21 and 010417-21 were related to care concerns; and

- Log #008945-21 was a follow up to CO #001 from inspection #2021_526645_0009 regarding s. 19. (1), with a compliance due date of July 5, 2021.

Inspector Wing-Yee Sun (Inspector #691930) attended this inspection during orientation.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Nursing (DON), Nurse Manager (NM), IPAC lead, Acting Building Services Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), food service aides, building services staff, residents and resident family members.

During the course of this inspection, the inspector reviewed residents' clinical records and conducted observations, including staff-resident interactions, meal observations and resident care provisions.

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

3 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2021_526645_0009	763

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. (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 staff and others involved in the different aspects of care collaborated with each other in the assessment of a resident so that their assessments were integrated, consistent with and complemented each other.

The resident was admitted to the home with several risk factors for injury noted on admission. Staff implemented several interventions in their plan of care to manage that risk.

Inspector #763 observed the resident in their room with several risks for injury present. This was in contradiction to the interventions implemented by staff in the resident's plan of care. Staff interviews indicated that the resident's status changed at least one month prior to the inspector's observation, and the implemented interventions were no longer required. After the inspector shared their observations with the home's staff, RN #117 conducted an assessment of the resident's risk for injury and modified the plan of care interventions. They also referred to the home's Behavioural Support Outreach (BSO) nurse for review.

BSO nurse and staff interviews acknowledged that an interprofessional

assessment of the resident's current risk for injury should have been conducted when their needs first changed. BSO #112 confirmed that they needed to be updated when the resident's condition first changed so that a thorough assessment of their behavioural needs was completed.

Sources: resident clinical records (PointClickCare profile, progress notes, care plan), observations, staff interviews (PSW #104, RPN #103 & #105, BSO #112, RN #117, and DON #114). [s. 6. (4) (a)]

2. The licensee has failed to ensure that a resident was reassessed and the plan of care revised when the care set out in the plan was no longer necessary.

The resident was admitted to the home with several risk factors for injury noted on admission. Staff implemented several interventions in their plan of care to manage that risk.

Inspector #763 observed the resident in their room with several risks for injury present. This was in contradiction to the interventions implemented by staff in the resident's plan of care. Staff interviews indicated that the resident's status changed since at least one month prior to the inspector's observation. Staff indicated that they forgot to update the resident's plan of care with this information when it was no longer necessary.

Sources: resident clinical records (PointClickCare profile, progress notes, care plan), observations, staff interviews (PSW #104, RPN #103 & #105, BSO #112, RN #117, and DON #114). [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 in ensuring that staff and others involved in the different aspects of care collaborate with each other in the assessment of residents so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to a resident unless the drug had been prescribed.

Inspector #763 observed the resident with several types of medications on their possession. Record review indicated that there were no orders for these medications to be self-administered by the resident.

Staff interviews confirmed they were aware that the resident was self-administering the above medications and obtained them from an external source. Staff acknowledged that an order for self-administration of the above substances should have been prescribed by the physician when they were first acquired.

Sources: resident clinical records (PointClickCare profile, medical and treatment administration records, progress notes, care plan), observations, staff interviews (PSW #104, RPN #105, RN #117, and DON #114). [s. 131. (1)]

Additional Required Actions:

(A1)
The following Voluntary Plan of Correction has been Revoked.

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 in ensuring that no drug is used by or administered to residents unless the drug has been prescribed, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff #106 participated in the implementation of the infection prevention and control (IPAC) program when they did not clean frequently touched surfaces daily.

According to the Public Health Ontario document "Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings", high-touch surface cleaning in care areas needed to be performed at least daily.

As part of inspecting on routine IPAC practices in the home, inspector #763 interviewed several staff and conducted observations of the home to determine compliance with IPAC protocols.

Day shift building services staff were expected to clean frequently touched surfaces, such as hallway handrails and elevator buttons, at least once daily during their shift. Staff #106, a full-time staff scheduled for day shifts, acknowledged they did not conduct this cleaning as they believed this was not their responsibility.

Management staff confirmed that high-touch surface cleaning needed to be completed at least once daily by the day-shift staff.

Sources: resident care area observations; PHO "Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings", 3rd Edition, April 2018; building services staff job routines; staff interviews (staff #106, IPAC lead #109, and other staff). [s. 229. (4)]

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 in ensuring that staff participate in the implementation of the IPAC program, to be implemented voluntarily.

Issued on this 7 th day of January, 2022 (A1)

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

Original report signed by the inspector.