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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 23, 2013	2013_159178_0022	T-566-13/T-497-13	Complaint

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET, METRO HALL, 11th FLOOR, 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

SUSAN LUI (178)

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): September 30, October 1, 2, 3, 8, 9, 11, 21, 2013

During the course of the inspection, the inspector(s) spoke with residents, Administrator, Acting Director of Nursing, Nurse Managers, registered staff, personal support workers (PSWs).

During the course of the inspection, the inspector(s) observed resident care, reviewed resident records, reviewed home records.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

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	Legendé 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 residents are protected from abuse by anyone.

Staff and resident interviews confirm that on August 14, 2013, resident # 2 was handled unnecessarily roughly by a staff member in the home.
On August 14, 2013 resident # 2 slid to the floor while trying to self transfer from bed to wheelchair. Staff member A was summoned to the room and was unable to assist the resident alone. Staff member B was then summoned to the room and according to statements from the resident and staff A, staff B picked the resident up from the floor and slammed the resident onto the bed, and then into the wheelchair in an angry and aggressive manner. Resident # 2 and staff A stated that staff B appeared angry and did not speak to the resident at all before, after or during the encounter. [s. 19. (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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director under the Long Term Care Homes Act (LTCHA).
Staff interviews and record review confirm that staff of the home failed to immediately report a witnessed incident of physical abuse of a resident by a staff member.
Staff member A failed to immediately report a witnessed incident of a resident being handled roughly by staff member B, to the Director under the LTCHA. The witnessed incident of rough handling occurred on August 14, 2013. Staff member A discussed the incident with the resident the following day and the resident confirmed that he/she was unhappy with the treatment he/she had received from staff B, and wished to report it to the home's management. Staff A advised the resident to report the incident to the acting Director of Care, but did not report the incident herself, either to the home's management or to the Director under the LTCHA. Staff A did eventually report the incident to the home's acting Director of Nursing on August 19, 2013.
Staff interviews indicate that an investigation into the incident began incident began on August 19, 2013. The abuse allegation was not reported to the Director under the LTCHA until a further three days had passed, on August 22, 2013. [s. 24. (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 a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, immediately reports the suspicion and the information upon which it was based to the Director under the Long Term Care Homes Act (LTCHA), to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning techniques when assisting residents.
Staff interviews and record review confirm that on August 14, 2013 staff member B lifted resident # 2 independently from the floor to the bed after the resident had slid to his/her knees on the floor when attempting to transfer from bed to wheelchair. Staff member A was present during the transfer, but was signaled by staff B that she would transfer the resident independently. The transfer from floor to bed was done quickly, and then the resident was transferred from bed to chair by staff B independently.
At no time was the resident spoken to by staff B or involved in the transfer. No explanation took place between staff B and the resident before, during or after the transfer.
The resident later told staff A and this inspector that he/she found the transfer to be rough, and felt that he/she was slammed into her chair with more force than was necessary to accomplish the task. [s. 36.]

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 use safe transferring and positioning techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff receive training in the area of mandatory reporting under section 24 of the Act of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident, prior to performing their responsibilities.
Staff interviews and record review confirm that staff are not trained that they have a mandatory duty to report suspected abuse of a resident to the Director under the Long Term Care Homes Act (LTCHA). Staff interviews and record review confirm that staff are trained that it is mandatory that they report alleged, suspected or witnessed abuse immediately to the registered nurse (RN) or registered practical nurse (RPN), and that it is the responsibility of the RN or RPN to inform an inspector for the Ministry of Health and Long Term Care that an alleged, suspected or witnessed incident of abuse or neglect has become known. [s. 76. (2) 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 to ensure that staff receive training in the area of mandatory reporting under section 24 of the Act of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident, prior to performing their responsibilities, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director under the Long Term Care Homes Act (LTCHA) regarding an allegation of staff to resident abuse, included whether an inspector has been contacted, and if so the date of the contact and the name of the inspector.
Staff interviews and record review confirm that home management verbally informed the Ministry of Health and Long Term Care (MOHLTC) of an allegation of staff to resident abuse on September 23, 2013, the same day that the home received knowledge of the abuse. However, the Critical Incident Report which was subsequently submitted regarding the incident, did not include the fact that an inspector had been contacted, the date of the contact or the name of the inspector. [s. 104. (1) 5.]

Issued on this 23rd day of October, 2013

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

Susan Lin (178)