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**

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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 |
|---|---|---|---|
| Feb 27, 2014 | 2013_109153_0029 | T-330-13, T-354-13 | Critical Incident System |

**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**

LYNN PARSONS (153)

## 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): December 4, 5, 6, 9, 10, 11, 12, 16, 2013.

During the course of the inspection, the inspector(s) spoke with Administrator, Acting Director of Nursing(DON), Nurse Managers, Behaviour Support Nurse, Counsellor, Registered Nurses(RN), Registered Practical Nurses(RPN), Personal Care Aides(PCA), Resident Assessment Instrument Co-Ordinator(RAI), Support Assistant and Residents.

During the course of the inspection, the inspector(s) reviewed resident clinical records, staff schedules, staff training records, home policies and procedures related to Prevention of Abuse, Responsive Behaviours, Altercations and Potentially Harmful Interactions Between and Among Residents and 24 Hour Admission Care Plan.

PLEASE NOTE: A non-compliance was found related to the Licensee's failure to ensure there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident under the Long Term Care Homes Act.
This non-compliance [LTCHA s.6(1)c] was issued in Inspection # 2013_109153_0027, conducted on November 14, 2013 and is contained in the Report of that Inspection.

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

Findings of Non-Compliance were found during this inspection.

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. Every resident has the right to be properly groomed and cared for in a manner consistent with his or her needs.
The written plan of care for resident #52 and the staff interviews confirmed the resident requires extensive assistance from one staff member for dressing and grooming.
On an identified date resident # 52 was transported back to the resident's room following a shower and directed to dress self without any assistance from staff.
Another staff found the resident very upset and frustrated at not being able to dress self without assistance from a staff member.
The second staff member assisted the resident to dress and transported the resident to the nurses station to report the concern at not receiving care consistent with the resient's needs. [s. 3. (1) 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 every resident is properly groomed and cared for in a manner consistent with his or her needs, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan**

**Specifically failed to comply with the following:**

**s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:**
**2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).**

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**Findings/Faits saillants :**

1. The licensee did not ensure the admission care plan includes at a minimum any risks the resident may pose to others, including any potential behavioural triggers and safety measures to mitigate those risks.
A review of the Long Term Care Application Assessment completed by the Community Care Access Centre indicated that resident #51 exhibited the following behaviours which required frequent monitoring: pacing, restlessness, confusion and agitation on days and nights.
The 24 hour admission care plan for Resident # 51 did not identify these behaviours or safety measures to mitigate the risks these behaviours presented.
An altercation occurred when Resident #51 wandered into another resident's room and frightened the other resident who was sleeping.
The intrusion resulted in an altercation between the two residents with minor injuries.
A review of the 24 hour plan of care failed to identify any documentation related to the behaviours exhibited by Resident #51.
The acting nurse manager confirmed the 24 hour admission care plan did not address the exhibited behaviours. [s. 24. (2) 2.]

***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 the admission care plan includes at a minimum any risks the resident may pose to others, including any potential behavioural triggers and safety measures to mitigate those risks, to be implemented voluntarily.***

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**WN #3: 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 failed to ensure that the report to the Director under the Long Term Care Homes Act regarding an allegation of staff to resident abuse included whether an inspector had been contacted, and if so the date of the contact and the name of the inspector.
The nurse manager confirmed the Critical Incident Report submitted to the Ministry did not indicate whether an inspector had been contacted regarding the allegation of staff to resident abuse on the identified date. [s. 104. (1) 5.]

**Issued on this 27th day of February, 2014**

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

L. Parsons