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**
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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_207147_0029 | T-101-13 | 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**

LALEH NEWELL (147)

## Inspection Summary/Résumé de l'inspection

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

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, 10, 11, 12 and 16, 2013

PLEASE NOTE: An area of non-compliance was found related to the Licensee's failure to protect resident #101 and #105 from Abuse by anyone under the Long Term Care Home's Act.
This non-compliance [LTCHA s. 19(1)] was issued in Inspection #2013_109153_0027 initiated on November 14, 2013 and is contained in the report of that inspection.

T-101-13
T-102-13
T-467-13
T-601-13

During the course of the inspection, the inspector(s) spoke with Administrator, Acting Director of Care (DOC), Nurse Managers, Behavioural Support Nurse, Counselor, Personal Care Assistant (PCA), Registered staff and Residents.

During the course of the inspection, the inspector(s) reviewed resident clinical records, home's internal investigation notes, staff personnel files, home's policy and procedure related to Responsive Behaviours and Prevention of Abuse and Neglect.

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. 20. Policy to promote zero tolerance**

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

**s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that without in any way restricting the generality of the duty provided for in section 19, a written policy to promote zero tolerance of abuse and neglect of residents, is complied with.

Review of the resident #105's plan of care and interview with the registered staff indicated the resident requires extensive assistance of two staff related to bathing as resident is very resistive to care and the resident's mode of locomotion is via wheelchair.

On an identified day in 2013 it was alleged that staff overheard slapping sounds and the resident crying and screaming from inside of the shower room while two identified staff were providing care to the resident. Later while an identified staff was transporting the resident out of the shower room back to resident #105's room, other staff on the unit overheard the identified staff member verbalize derogatory comment to the resident.

Review of the home's internal investigation notes and interview with the staff indicate that these allegations of physical and verbal abuse were not reported to the home by the registered staff, therefore the home did not notify the Director and did not commence an internal investigation into these allegations immediately.
Review of the home's policy and procedure "Zero Tolerance of Abuse & Neglect of Residents: Reporting and Investigating" policy number RC-0305-02, last revised on May 1, 2013, requires the registered staff to assess and examine the resident, notify the physician, inform the nurse manager and DOC immediately, notify family or responsible party for the involved resident immediately and document incident, assessment and resident status in progress notes. Review of the home's investigation notes and interview with the registered staff on the unit at the time of the incident, confirmed that the home's written policy to promote zero tolerance of abuse and neglect of the resident was not complied with. [s. 20. (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 without in any way restricting the generality of the duty provided for in section 19, the home's written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.*

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**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).**

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**Findings/Faits saillants :**

1. The licensee failed to ensure a person who has reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or a risk of harm to the resident has occurred or may occur immediately reports the suspicion and the information upon which it is based to the Director.

On an identified date in 2013 resident #101 reported to the registered that an identified staff member struck the resident when the resident attempted to remove washcloths for evening care from the linen cart. Interview with the registered staff indicated the resident was assessed at the time of the incident, no injuries were noted and there were no behaviours changes as a result of the incident.
Interview with the nurse manager and review of the home's internal incident report confirmed that the incident was reported to the manager on call at the time of incident, however the Director was not immediately notified in relation to the allegation of abuse of the resident by anyone. [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 a person who has reasonable grounds to suspect that any abuse of a resident by anyone that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.**

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**Findings/Faits saillants :**

1. The licensee failed to ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

On an identified dated in 2013 resident #101 reported to the registered staff that an identified staff member struck the resident when the resident attempted to remove washcloths for evening care from the linen cart. Interview with the registered staff indicated the resident was assessed at the time of the incident, no injuries were noted and there were no behaviour changes as a result of the incident.
Interview with the nurse manager and review of the home's internal incident report confirmed that the incident was reported to the manager on call at the time of incident, however the appropriate police force was not immediately notified of the allegation of abuse towards resident #101 until a week later. [s. 98.]

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**Issued on this 13th day of March, 2014**

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

Laleh Nevell