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
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Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 20, 2014	2014_159178_0006	T-219-14	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), MATTHEW CHIU (565)

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): March 20, 24, 25, 26, 27, 31, April 9, 10, 14, 2014.

During the course of the inspection, the inspector(s) spoke with Assistant Administrator, Director of Care, Nutrition Manager, Registered Dietitian, Nurse Manager, registered staff, personal care assistants (PCAs), family of a resident.

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

The following Inspection Protocols were used during this inspection:

Falls Prevention
Nutrition and Hydration
Reporting and Complaints
Sufficient Staffing

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 O.Reg 79/10, s. 69. Weight changes

Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months

Record review and staff interviews confirm that resident # 1 repeatedly experienced weight loss exceeding 5 percent over one month, exceeding 7.5 percent over three months, and exceeding 10 percent over six months. During this time the resident's weight loss was not assessed using an interdisciplinary approach, and actions were not taken in regards to the weight loss.
Record review confirms that resident # 1 experienced the following weight losses:
December 2013:
6 percent over one month
11.9 percent over three months
16.7 percent over six months
January 2014:
13.7 percent weight loss over six months
February 2014:
10.1 percent over one month
14.3 percent over 3 months
22.5 percent over six months
March 2014:
9.8 percent over three months
20.5 percent over six months.

The cause of resident # 1's weight losses was not assessed and actions were not taken. It was noted on the December 2013 and March 2014 Quarterly Nutrition Reviews, completed by the home's Nutrition Manager, that resident # 1 would be referred to a registered dietitian (RD), but no referral took place. The resident's weight loss was not assessed by an RD until the oversight was identified by inspectors at the time of this inspection.

Staff interviews and record review confirm that the percentage of resident # 1's weight loss was not monitored on a monthly basis or every six months. The percentage of the resident's weight loss was only monitored quarterly. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care sets out clear directions to staff who provide direct care to the resident. Staff interviews, family interview and record review confirm the following:
Resident # 1 requires a reclining shower chair for safety during showers, and has required this intervention for at least six months before the fall incident described below, occurred. Interviews with the resident's family and a number of staff members, confirm that the resident requires a reclining shower chair for safety, as the resident is prone to leaning forward unpredictably in the chair, and that the resident has normally been showered using a reclining shower chair since well before an incident when the resident fell from the non-reclining shower chair. On that identified date, a personal care assistant (PCA) showered resident # 1 using a non-reclining shower chair. During the shower, the PCA turned away from the resident to retrieve a towel, at which time resident # 1 leaned forward and fell off of the non-reclining shower chair. The resident sustained lacerations, requiring transfer to and treatment in hospital Emergency Room before being transferred back to the LTCH. The PCA involved in this incident, who works full time on the resident's unit, stated to inspectors that he/she had never used a reclining shower chair for resident # 1. Staff interviews and review of resident # 1's written plan of care confirmed that prior to the resident's fall, the resident's need for a reclining shower chair was not present in the resident's written plan of care. After the resident's fall, resident # 1's written plan of care was amended to include the fact that a reclining shower chair must be used for this resident. [s. 6. (1) (c)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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 any policy instituted or otherwise put in place is complied with.

Record review and staff interviews confirm that the policy Unplanned Weight Changes (RC-0523-13), published January 9, 2013, was not complied with.
Staff interviews and record review confirm that the following procedures were not completed as per the above named policy:
-Resident # 1's weights for January 2014, February 2014 and March 2014 were not recorded on the resident's Weight Monitoring Record before the 10th of each month. On March 26, 2014, inspectors noted that the most recent weight recorded on the resident's Weight Monitoring Record was from December 2013.
-When resident # 1 experienced a greater than 2 kilogram (kg) change in weight in December 2013 and February 2014, the resident was not re-weighed as directed in the above named policy.
-Resident # 1 was not referred to the dietitian for significant weight losses identified in December 2013, February 2014, and March 2014, as directed in the above named policy. [s. 8. (1) (a),s. 8. (1) (b)]

2. Record review and staff interviews confirm that resident # 4 was not re-weighed as per the Unplanned Weight Changes policy (RC-0523-13), when a weight change of greater than 2 kg was identified in February 2014.
Resident # 4's weight in January 2014 was 111.9 kg and in February 2014 was 115.7 kg. The resident was not re-weighed after this weight change was identified. [s. 8. (1) (a),s. 8. (1) (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 to ensure that any policy instituted or otherwise put in place is complied with, to be implemented voluntarily.

Issued on this 10th day of June, 2014

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

(178)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN LUI (178), MATTHEW CHIU (565)
Inspection No. / No de l'inspection :	2014_159178_0006
Log No. / Registre no:	T-219-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 20, 2014
Licensee / Titulaire de permis :	TORONTO LONG-TERM CARE HOMES AND SERVICES 55 JOHN STREET, METRO HALL, 11th FLOOR, 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 :	Nancy Lew

To TORONTO LONG-TERM CARE HOMES AND SERVICES, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
The plan shall be submitted via email to susan.lui@ontario.ca by May 30, 2014.

Grounds / Motifs :

1. The licensee has failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months

Record review and staff interviews confirm that resident # 1 repeatedly experienced weight loss exceeding 5 percent over one month, exceeding 7.5 percent over three months, and exceeding 10 percent over six months. During

this time the resident's weight loss was not assessed using an interdisciplinary approach, and actions were not taken in regards to the weight loss.
Record review confirms that resident # 1 experienced the following weight losses:
December 2013:
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March 2014:
9.8 percent over three months
20.5 percent over six months.

The cause of resident # 1's weight losses was not assessed and actions were not taken. It was noted on the December 2013 and March 2014 Quarterly Nutrition Reviews, completed by the home's Nutrition Manager, that resident # 1 would be referred to a registered dietitian (RD), but no referral took place. The resident's weight loss was not assessed by an RD until the oversight was identified by inspectors at the time of this inspection.

Staff interviews and record review confirm that the percentage of resident # 1's weight loss was not monitored on a monthly basis or every six months. The percentage of the resident's weight loss was only monitored quarterly.

(178)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2014

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # /
Ordre no : 002

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all residents who require a reclining shower chair for safety, have written plans of care which set out clear directions to staff who provide care to the residents, particularly in regards to the type of shower chair to be used to ensure the resident's safety.
The plan will be submitted via email to susan.lui@ontario.ca by May 30, 2014.

Grounds / Motifs :

1. The licensee has failed to ensure that the written plan of care sets out clear directions to staff who provide direct care to the resident.
Staff interviews, family interview and record review confirm the following:
Resident # 1 requires a reclining shower chair for safety during showers, and has required this intervention for at least six months before the fall incident described below, occurred. Interviews with the resident's family and a number of staff members, confirm that the resident requires a reclining shower chair for safety, as the resident is prone to leaning forward unpredictably in the chair, and that the resident has normally been showered using a reclining shower chair since well before an incident when the resident fell from the non-reclining shower chair. On that identified date, a personal care assistant (PCA) showered resident # 1 using a non-reclining shower chair. During the shower, the PCA turned away from the resident to retrieve a towel, at which time resident # 1 leaned forward and fell off of the non-reclining shower chair. The resident sustained lacerations, requiring transfer to and treatment in hospital Emergency Room before being transferred back to the LTCH. The PCA involved in this incident, who works full time on the resident's unit, stated to inspectors that he/she had never used a reclining shower chair for resident # 1. Staff interviews and review of resident # 1's written plan of care confirmed that prior to the resident's fall, the resident's need for a reclining shower chair was not present in the resident's written plan of care. After the resident's fall, resident # 1's written plan of care was amended to include the fact that a reclining shower chair must be used for this resident.
(178)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2014

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 20th day of May, 2014

Signature of Inspector / Signature de l'inspecteur : Susan Lui (178)

Name of Inspector / Nom de l'inspecteur : SUSAN LUI

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