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
Jun 11, 2014	2014_159178_0011	T-172-14/T-212-14/T-226-14	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

SUSAN LUI (178), SOFIA DASILVA (567)

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): April 8, 9, 10, 11, 14, 16, 17, 23, 28, May 1, 2, 5, 2014.

The following Intake Logs were inspected during this inspection:
T-172-14, T-212-14, T-226-14, T-275-14, T-317-14, T-437-14.
Note that the care of the resident experiencing responsive behaviours, named in intake # T-450-14, was inspected in this inspection, but the allegation of neglect in # T-450-14 was inspected in inspection # 2014_159178_0012.

During the course of the inspection, the inspector(s) spoke with Director of Nursing, registered staff, Behavioural Support nurses, Psychiatric Outreach Nurse, personal care assistants (PCAs).

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

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Responsive Behaviours

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Record review indicates that resident # 3 had decreased hearing, but refused to wear hearing aids. Staff interviews and record review indicate that during resident # 3's annual care conference held on February 6, 2014, it was decided by the care team that the resident's ears would be flushed every month by the resident's physician. Staff interviews and record review confirm that the resident did not have his/her ears flushed between the date of the conference and March 29, 2014 when the resident was sent to hospital for an unrelated issue.
Record review and staff interview indicate that resident # 3 last had his/her ears flushed in December 2013. [s. 6. (7)]

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 the care set out in residents' plans of care is provided to the residents as specified in the plans, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions, are documented.

Staff interviews confirm that resident # 3 exhibited responsive behaviours related to his/her anxiety over bowel movements (BMs) and constipation. The resident would become angry, frustrated, and verbally aggressive when his/her bowels did not move as frequently as the resident felt they should. Review of the resident's Nursing Practice Care Record (NPCR), where the resident's BMs are documented, indicates that the resident's BMs were not consistently documented by staff. On several dates the resident's NPCR shows no documentation that the resident had a BM, even though staff agrees that the resident had a BM daily or almost daily.
Review of the resident's NPCR for March 2014 confirms that there are missing entries in documenting the resident's BMs on 24 dates during the month. In particular, during an eight day period between March 13 and March 21, 2014 there is no indication anywhere in the resident's record that the resident had a BM. [s. 30. (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 that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions, are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

1. The licensee failed to ensure that strategies are developed and implemented to meet the needs of residents who cannot communicate in the language used in the home.

Staff interviews and record review confirm the following:
Resident # 4 predominantly speaks a language other than English. The resident exhibits responsive behaviours, and is under the care of the Geriatric Mental Health Outreach Team (GMHOT). On March 11, 2014, resident # 4 had a previously scheduled appointment with the psychiatrist for the GMHOT. The psychiatrist does not speak Resident # 4's language. Arrangements were not made to ensure that an interpreter was available for the appointment, and as a result, the psychiatrist's assessment was abbreviated, due to the language barrier.
Subsequent to this appointment, on March 23, 2014 the home issued a memo to all Behavioural Support Clinic staff, registered nurses and counselors, instructing them to ensure that for all residents, the power of attorney (POA) or substitute decision maker (SDM) or alternate attends clinic appointments when there are communication and/or language barriers. If this is not possible, the staff is instructed to appoint a staff member to translate if the appointment is critical, and to consult with the psychiatrist if the appointment needs to be re-scheduled.
During interviews for this inspection on May 2, 2014, the Behavioural Support Clinic staff was aware of this memo, and confirmed that it is now their usual practice. [s. 43.]

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 strategies are developed and implemented to meet the needs of residents who cannot communicate in the language used in the home, to be implemented voluntarily.

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Issued on this 11th day of June, 2014

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

(178)