Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 27, 2021	2020_610633_0029	006795-20, 012595-20, 014379-20, 015912-20, 015980-20, 016137-20, 023834-20	Complaint

Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 365 Bloor Street East, 15th Floor Toronto ON M4W 3L4

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

SHERRI COOK (633), JANETM EVANS (659)

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): December 8-11, 14-17, 21-23, 2020.

The following intakes were completed during this inspection:

**Log #'s 016137-20 and 015980-20- related to missing residents.
Complaint Log #'s 006795-20, 012595-20, 014379-20, 015912-20, and 023834-20- related to a bed refusal, alleged neglect and pain, resident bill of rights, personal items and alleged abuse and care concerns.**

Critical Incident (CI) inspection 2020_610633_0028 was completed concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Administrator, a Nurse Practitioner (NP), Nurse Managers (NMs), Registered Nurses (RNs), the Infection Prevention and Control Lead (IPAC Lead), an Occupational Therapist (OT), a Social Worker (SW), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Physiotherapist Aide (PTA), a Support Assistant (SA), a Personal Care Assistant (PCA) and residents.

The inspector(s) observed resident care/staff interactions, medication administration and IPAC practices. The plan of care for the identified residents and the home's related documentation and policies were also reviewed.

**The following Inspection Protocols were used during this inspection:
Admission and Discharge
Dignity, Choice and Privacy
Hospitalization and Change in Condition
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Safe and Secure Home
Trust Accounts**

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
3 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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	Légende 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. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the home's policy of restraining devices was complied with for three residents.

The home’s policy of restraining devices provided the criteria to be followed for restraints prior to use that included a comprehensive interdisciplinary assessment, which clearly identified the risk, the alternative methods to the restraints that had been tried and proven ineffective, a review of the potential risks and benefits fully explained to the resident or substitute decision maker (SDM), and consent was to be obtained from the resident if capable of making treatment decisions. An initial restraint assessment was to be completed.

Two residents was observed wearing a restraint. They were both unaware of the purpose. The residents were capable and could make their own decisions. Another resident was observed with a restraint. There were no restraint assessments completed which documented the risk and the alternative methods that were tried before use.

Sources: Observation/Interview with the resident's; the home's restraint policy (2019); interviews with a RN and NM.

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. 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:
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee has failed to ensure that a resident's right to share a room with another resident according to their mutual wishes was fully respected and promoted if appropriate accommodation was available.

A resident was moved from their room, which they had shared with another resident, to complete 14 days of isolation related to COVID-19 protocols. In December, the residents remained in separate rooms. Both residents said they would like to be united and one resident had repeatedly told staff. The NM acknowledged that residents had the right to share a room with a person of their choosing if this was mutual and a room was available however, the IPAC lead said they would only re-unite them after the outbreak was over. There were empty rooms at the home. There was a potential risk to the residents' mental health, safety and well being if they could not be re-united to share a room.

Sources: Interviews with two resident's; progress notes; interviews with NM and the IPAC Lead.

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 that have mutual wish to share a room are provided a room together when appropriate accommodation was available, to be implemented voluntarily.

WN #3: 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 :

The licensee has failed to ensure that the administration of an intervention every day in the morning was provided to a resident as specified in their plan of care.

The resident was involved with Behavioural Supports (BSO). Staff were directed to refer to the electronic medication administration record (eMAR) for administration of an intervention at the specified time to better manage the resident's condition and behaviours however, from December 1–16, 2020, the resident had not been provided the intervention on 7 out of sixteen days. The resident's plan of care should have been followed however, it was not. The risk to the resident was potential increased behaviours.

Sources: Interview with the resident; the resident's physician order, eMAR, progress notes, care plan; interviews with a RPN and RN.

2. The licensee failed to ensure that staff provided care and assistance that was set out in the plan of care for two residents as specified in their plans.

A resident was observed seated upright in bed not shaved, their hair was dishevelled and they were in their pyjamas. An hour later, the resident remained in bed in the same state. The resident said they had asked to get up, but they were not provided the assistance by staff to do so. Staff were directed that the resident required weight bearing assistance and one staff person assistance for transfers, dressing, toileting and personal hygiene.

Another resident was observed repeatedly asking for help. They said they had asked for help three times and no one helped them. The resident later called out for assistance and a PSW staff member told the resident they could not get up. The staff member left the room and reported to a RPN. The RPN attended the room and told the resident to get back in bed so they did not fall. They said they would return at 1000 hours to get them

washed up and transferred to their chair. The plan of care directed staff that the resident required extensive weight-bearing assistance with bed mobility, transfers, dressing and personal hygiene. The resident preferred to get up at 0700 hours.

All residents were to be up for breakfast, morning care was to be provided and the care plan was to be followed however, this did not occur. The potential risk to the residents of staff not providing assistance per the residents' plan of care was that the residents may attempt to self transfer, fall and sustain an injury.

Sources: Observations/Interview with the residents; the residents' plan of care; PSW responsibilities/job routine (January 2018); interviews with a PSW, a RPN, a RN and others.

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 plan of care is provided to resident's as specified in their plan of care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

The licensee has failed to ensure that two residents were not restrained for the convenience of the licensee or staff.

The residents were restrained by the use of a device and a assistive device was removed to prevent them from independently leaving any part of the home or grounds of the home.

A resident was observed wearing a restraint. This resident did not know what the restraint was. The resident also said they had a device taken from them so they could not leave the home. The residents' care plan directed staff that the resident used the device and there was no provision for the restraint in the resident’s care plan.

Another resident was observed wearing a restraint. A device taken from them so they could not leave the home. The resident said they could not go anywhere and it felt like they were in prison. They were told by staff that it would not be returned to them until after the outbreak was over. The use of the restraint was to minimize the resident’s ability to leave the unit or the property. There was no provision for the restraint in the resident’s care plan.

Staff had been asked to do whatever they needed to do to keep residents on the unit as an infection prevention and control (IPAC) measure.There was a potential risk to the residents' mental health and well being related to their loss of independence.

Sources: Observations/Interview with the residents; the residents' care plan and progress notes; the home's restraint policy (2019); interviews with a NM, IPAC Lead and others.

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 not retrained for the convenience of the licensee or staff, to be implemented voluntarily.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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

Issued on this 1st day of February, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHERRI COOK (633), JANETM EVANS (659)
Inspection No. / No de l'inspection :	2020_610633_0029
Log No. / No de registre :	006795-20, 012595-20, 014379-20, 015912-20, 015980-20, 016137-20, 023834-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 27, 2021
Licensee / Titulaire de permis :	City of Toronto c/o Seniors Services and Long-Term Care, 365 Bloor Street East, 15th Floor, Toronto, ON, M4W-3L4
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 :	Tim Burns

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

To City of Toronto, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 29. (1) Every licensee of a long-term care home,

(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and

(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Order / Ordre :

The Licensee must be compliant with s. 29 of the LTCHA.

Specifically, the licensee must ensure that:

All staff follow the licensee's policy of restraints. This includes, but is not limited to:

1. A resident is restrained only if there is imminent risk that the resident or another person would suffer serious bodily harm if the resident were not restrained. An interdisciplinary assessment to identify and document the risk must be completed.
2. Prior to application of any restraint, alternatives to restraining the resident have been tried and proven ineffective to address the risk. These alternatives must be documented.
3. The restraining of the resident has been consented to by the resident, if capable. If the resident is incapable, a substitute decision-maker of the resident who has authority to give the consent may do so.
4. Restraining of a resident must be included in the resident's plan of care.

Grounds / Motifs :

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

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

1. The licensee has failed to ensure that the home's policy of restraining devices was complied with for three residents.

The home’s policy of restraining devices provided the criteria to be followed for restraints prior to use that included a comprehensive interdisciplinary assessment, which clearly identified the risk, the alternative methods to the restraints that had been tried and proven ineffective, a review of the potential risks and benefits fully explained to the resident or substitute decision maker (SDM), and consent was to be obtained from the resident if capable of making treatment decisions. An initial restraint assessment was to be completed.

Two residents was observed wearing a restraint. They were both unaware of the purpose. The residents were capable and could make their own decisions. Another resident was observed with a restraint. There were no restraint assessments completed which documented the risk and the alternative methods that were tried before use.

Sources: Observation/Interview with the resident's; the home's restraint policy (2019); interviews with a RN and NM.

An order was made taking the following factors into account:

Severity: There was a potential risk that residents were inappropriately restrained if they were not appropriately assessed; alternatives to restraints considered and tried, and informed consent was not obtained prior to the application of a restraining device.
Scope: This issue was a wide spread as three out of three residents reviewed were impacted.
Compliance History: The home had no non-compliance related to this section in the past 36 months.
(659)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 26, 2021

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 27th day of January, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sherri Cook

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