Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: March 26, 2024
Inspection Number: 2024-1536-0002
Inspection Type: Complaint
Licensee: City of Toronto
Long Term Care Home and City: Castleview Wychwood Towers, Toronto

Lead Inspector	**Inspector Digital Signature**
Oraldeen Brown (698)	Oraldeen Brown Digitally signed by Oraldeen Brown Date: 2024.04.04 10:15:41 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 12, 13, 14, 15, 16, 21, 22, 2024.

The inspection occurred offsite on the following date(s): February 26, 2024.

This inspection was conducted concurrently with inspection #2024-1536-0001.

The following complaint intake(s) was inspected:

- Intake: #00106349 related to abuse, pest control, infection prevention and control.

The following **Inspection Protocols** were used during this inspection:

Housekeeping, Laundry and Maintenance Services

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 4.

Residents' Bill of Rights

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 freedom from abuse.

The licensee has failed to ensure that resident #001's right to be free from abuse was fully respected when they experienced physical abuse by resident #002.

Rationale and Summary

An incident occurred involving resident to resident abuse of resident #001 by resident #002.

Resident #001 told the inspector that when they were struck by resident #002, they experienced pain and continues to have pain. Resident #001 acknowledged that they remain fearful of resident #002 returning to cause them further harm. The incident was witnessed by a Personal Support Worker (PSW).

The PSW, Nurse Manager (NM), and the Behaviour Support Ontario (BSO) lead acknowledged that resident #001's Bill of Rights were not respected when physical

abuse occurred when resident #002 struck resident #001.

Failure to ensure resident #001 was free from abuse violated their Bill of Rights resulting in pain after they were struck.

Sources: Critical Incident Systems (CIS) report #M150-000045-23, resident #001's clinical records, interview with resident #001, PSW, NM, BSO lead and other relevant staff.
[698]

WRITTEN NOTIFICATION: Directives by Minister

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee has failed to carry out every operational directive that applied to the long-term care home.

Specifically, per section 1.2 of the Minister's Directive: COVID-19 response measures for long-term care homes, the licensee was required to ensure that the masking requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, or as amended, were followed.

Rationale and Summary
A Registered Nurse (RN) was observed without a mask in the nursing station within two meters of other staff, and in the central dining room when coming into contact

with residents.

The RN acknowledged that they were not wearing a mask due to certain challenges. The NM acknowledged that masking was mandatory for everyone inside the home and should be worn at all times.

The Director of Nursing (DON) acknowledged that the RN should have informed the home of their challenges surrounding wearing a mask.

Failure of staff to adhere with Personal Protective Equipment (PPE) requirements as required increased the risk of transmission of infection.

Sources: Observations, COVID-19 guidance document for long-term care homes, interviews with the RN, NM, and other relevant staff.
[698]

WRITTEN NOTIFICATION: Pest control

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 94 (2)
Pest control
s. 94 (2) The licensee shall ensure that immediate action is taken to deal with pests.

The licensee has failed to ensure that immediate action was taken to deal with pests.

Rationale and Summary
The home had protocols in place on all floors for documenting pest sightings on each unit.

There was no documentation of pest sighting in the pest control binder on a home area when a Food Service Worker (FSW) mentioned they had seen a pest in the servery.

The FSW acknowledged that they saw a pest in the servery two weeks prior. They killed it but did not document it in the pest control binder located on the unit or reported it to anyone.

The NM's expectation of staff was to document pest sightings in the pest control binder on the unit or inform the nurse manager on the unit. Otherwise, the pest control contractors would not have known which areas to treat.

Failure to document and report pest sightings can delay identification of pest control in the home.

Sources: Pest control binder, interview with FSW and other relevant staff.
[698]