

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

Public Report

Report Issue Date: December 18, 2024

Inspection Number: 2024-1536-0005

Inspection Type:

Critical Incident

Licensee: City of Toronto

Long Term Care Home and City: Castlerview Wychwood Towers, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 4-6, 9-10, 2024

The following intake(s) were inspected in this Critical Incident (CI) inspection:

- Intake: #00124507 [CI: M510-000042-24] - Related to a resident fall resulting in injury
- Intake: #00125213 [CI: M510-000044-24] - Related to outbreak management
- Intake: #00127347 [CI: M510-000047-24] - Related to neglect with continence care and pain management

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

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WRITTEN NOTIFICATION: Falls Prevention and Management

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

Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to comply with the falls prevention and management program for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to have a falls prevention and management program that must be complied with.

The home did not comply with the home's Falls Prevention and Management policy related to sending a referral.

Rationale and Summary

A resident had a fall. A referral was sent to the physiotherapist (PT) for a post-fall assessment. The resident's clinical records indicated the PT suggested a falls prevention intervention and the nurse was required to send the referral to the occupational therapist (OT) for the intervention.

The Director of Nursing (DON) indicated that no OT referral was sent by the PT for a falls prevention intervention.

Failure to follow the home's Falls Prevention and Management policy caused a

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potential delay in the initiation of a falls prevention intervention for the resident, resulting in risk of further injury.

Sources: A resident's clinical records, the home's Falls Prevention and Management Policy, interview with the DON.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The Licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control (IPAC). Specifically, the Licensee failed to ensure that, at a minimum, quarterly audits were conducted to ensure that all staff can perform the IPAC skills required for their role in accordance with Section 7.3 (b) of the Infection Prevention and Control (IPAC) Standard.

Rationale and Summary

During a COVID-19 outbreak, no quarterly audits related to staff performance of Infection Prevention and Control (IPAC) skills were completed.

The IPAC Lead was unable to provide any audits that were completed during the

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above mentioned period.

Failure to follow the IPAC standard and complete quarterly IPAC skills audits of staff, to ensure they could perform the required IPAC skills of their role, increases the risk of infection transmission.

Sources: Review of the home's staff quarterly IPAC audit records, IPAC Standard for Long-Term Care Homes (LTCH), and interviews with the IPAC Lead.