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
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Public Report

Report Issue Date: September 12, 2025
Inspection Number: 2025-1536-0006
Inspection Type:
Critical Incident
Follow up

Licensee: City of Toronto
Long Term Care Home and City: Castleview Wychwood Towers, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 26, 28-29, September 2-5, 8-9, and 11-12, 2025.

The following intake(s) were inspected:
- Intake: #00148376, Intake: #00150691, Intake: #00151282 - Related to falls prevention and management
- Intake: #00149434 - Related to injury of unknown cause
- Intake: #00153731 - Follow-up on Compliance Order (CO) #001 related to falls prevention and management
- Intake: #00154286 - Related to responsive behaviors

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1536-0004 related to O. Reg. 246/22, s. 53 (1) 1.

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

Resident Care and Support Services
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Required programs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
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:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee has failed to ensure that the pain management program was implemented in the home to manage a resident's pain.

Staff identified a resident's pain during two consecutive shifts. No comprehensive pain assessments or interventions were implemented to manage the resident's reported pain during both shifts.

The home confirmed that staff should have completed comprehensive pain assessments and implemented interventions to manage the resident's pain when it was identified.

Sources: Resident clinical records, home's investigation notes; and interview with staff.