



**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**

**Long-Term Care Homes Division  
Long-Term Care Inspections Branch**

**Division des foyers de soins de  
longue durée  
Inspection de soins de longue durée**

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**Public Copy/Copie du public**

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<b>Report Date(s) / Date(s) du rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Jan 29, 2018	2017_370649_0023	028762-17	Resident Quality Inspection

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**Licensee/Titulaire de permis**

City of Toronto  
55 JOHN STREET METRO HALL, 11th FLOOR TORONTO ON M5V 3C6

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**Long-Term Care Home/Foyer de soins de longue durée**

CASTLEVIEW WYCHWOOD TOWERS  
351 CHRISTIE STREET TORONTO ON M6G 3C3

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**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

JULIEANN HING (649), MATTHEW CHIU (565)

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**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Resident Quality Inspection.**

**This inspection was conducted on the following date(s): December 19, 20, 21, 22, 29, 2017, January 2, 3, 4, 5, 8, 9, and 10, 2018.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Administrator, Director of Nursing, Nurse Managers, Acting Nurse Manager, Nutrition Manager, Dietitians, RAI Co-ordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Support Services, Residents, and Family Members.**

**The inspectors conducted a tour of the resident home areas, observations of medication administration, staff and resident interactions, record review of resident and home records, meeting minutes for Residents' Council and Family Council, staffing scheduled and relevant policies and procedures.**

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

**Accommodation Services - Housekeeping  
Dignity, Choice and Privacy  
Falls Prevention  
Family Council  
Infection Prevention and Control  
Medication  
Nutrition and Hydration  
Prevention of Abuse, Neglect and Retaliation  
Residents' Council  
Skin and Wound Care**

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

**2 WN(s)  
1 VPC(s)  
0 CO(s)  
0 DR(s)  
0 WAO(s)**



The following previously issued Order(s) were found to be in compliance at the time of this inspection:

Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / DE L'INSPECTION	NO NO DE L'INSPECTEUR
O.Reg 79/10 s. 36.	CO #001	2017_635600_0008	649

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

Legend	Legendé
<p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

**Specifically failed to comply with the following:**

- s. 50. (2) Every licensee of a long-term care home shall ensure that,**
- (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
- (i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,**
  - (ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,**
  - (iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and**
  - (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented.

Resident #005 triggered from stage one of the Resident Quality Inspection (RQI) for skin and wound for altered skin integrity.

According to the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment and 005's plan of care indicated on identified dates the resident had an area of altered skin integrity on an identified body area.

A review of the home's altered skin integrity assessment record initiated on an identified date indicated resident #005 had an altered skin integrity on an identified body area. According to this assessment record a referral had been sent to the Occupational Therapist (OT) and Social Worker (SW) on an identified date and there was no indication that a referral had been sent to the Dietitian (RD).



A review of the home's policy titled Skin Care and Wound Prevention and Management, policy #RC-0518-02, published on January 4, 2016, directed the RN/RPN to initiate referrals for residents with altered skin integrity, including pressure ulcers, skin tears or wounds to the Dietitian.

Interviews with Registered Practical Nurse (RPN) #103 and nurse manager (NM) #113 revealed that no referral had been sent to the RD when resident #005 had developed an area of altered skin integrity on an identified body area.

Interview with RD #111 revealed they had not received a referral for resident #005 when an area of altered skin integrity had developed on an identified body area and therefore had not assessed the resident. [s. 50. (2) (b) (iii)]

2. Resident #006 triggered from stage one of the RQI for skin and wound for altered skin integrity.

According to the RAI-MDS assessment and 006's plan of care indicated on identified dates the resident had an area of altered skin integrity on an identified body area.

A review of the home's altered skin integrity assessment record initiated on an identified date indicated resident #006 had an area of altered skin integrity on an identified body area and according to this assessment no referral had been sent to the RD.

A review of the home's policy titled Skin Care and Wound Prevention and Management, policy #RC-0518-02, published on January 4, 2016, directed the RN/RPN to initiate referrals for residents with altered skin integrity, including pressure ulcers, skin tears or wounds to the Dietician.

Interviews with RPN #102 and acting nurse manager (A-NM) #120 revealed that no referral had been sent to the RD when resident #006 had developed an area of altered skin integrity on an identified date.

Interview with RD #115 revealed they had not received a referral for resident #006 when an area of altered skin integrity had developed on an identified body area and therefore had not assessed the resident. [s. 50. (2) (b) (iii)]



***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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

**Specifically failed to comply with the following:**

- s. 15. (2) Every licensee of a long-term care home shall ensure that,**
- (a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
  - (b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
  - (c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

Resident #002 triggered from stage one of the RQI for Accommodation Services of Housekeeping related to unclean ambulation equipment.

On December 19, 2017, at an identified time resident #002's wheelchair was observed by the inspector to be soiled beneath the left handle on the frame of the wheelchair and on the seat cushion.

On December 29, 2017, at an identified time resident #002's wheelchair was noted to be soiled on the back cushion with food stains, beneath the left handle on the frame of the



wheelchair, and brown spots noted on the left foot rest.

On January 3, 2018, at an identified time resident #002's wheelchair was observed to be soiled beneath the left and right handles on the frame of the wheelchair with dried food spots, a large spot noted on the back cushion and both front wheels were observed to be dirty.

On January 5, 2018, at an identified time resident #002's wheelchair was observed with yellow food spots on the seat cushion, dried food spots noted on both foot rests, and on both sides of the wheelchair frame. Dried food spots noted beneath the left and right handles on the frame of the wheelchair, two large yellow spots were observed on the right surface of the seat cushion, two white spots noted on left foot rest and the wheelchair frame was observed to be soiled.

A review of the home's policy titled Wheelchair Cleaning, policy # BS-0322-00, published date January 12, 2016, directed nursing staff to bring wheelchair to a predetermined location. Building Services staff will clean wheelchairs and return them back to the same location once cleaned. Under frequency indicated every two months and as required.

According to the wheelchair cleaning schedule and interview with NM #112 revealed that resident's wheelchairs are scheduled to be cleaned by cleaner heavy duty (CHD) once every six weeks on an identified day of the week.

Interviews on an identified date with Personal Support Worker (PSW) #108, RPN #109 and Registered Nurse (RN) #110 confirmed there are food marks on the right arm rest and stains of food and drink of some sort on the sides of resident #002's wheelchair and that the wheelchair required cleaning.

Interview with NM #112 revealed that resident #002's wheelchair was scheduled to be cleaned by the CHD on two identified dates and confirmed that the resident wheelchair had not been cleaned on these two dates. [s. 15. (2) (a)]



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**Issued on this 29th day of January, 2018**

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

**Original report signed by the inspector.**