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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 10, 2020	2020_767643_0009	010389-20	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

ADAM DICKEY (643)

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): May 27, 29, June 2 and 3, 2020, as an off-site inspection.

The following complaint intake was inspected during this inspection:
Log #010389-20 - related to falls prevention and management and nutrition and hydration.

A Critical Incident System (CIS) inspection (2020_767643_0008, Log #009299-20) was conducted concurrently during this inspection pertaining to the same fall incident.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Nurse Manager - Clinical (NM), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and resident family member(s).

During the course of the inspection the inspector reviewed resident health records, reviewed footage from the home's Closed Circuit Television System (CCTV) and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration

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

- **1 WN(s)**
- **1 VPC(s)**
- **0 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. 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 :

1. A complaint was received by the Director from resident #001's family member related to a fall incident and care concerns on an identified date. The complaint indicated that

they did not believe resident #001 had been provided assistance with feeding during a specified meal service, as the resident home area (RHA) was conducting a trial of room service during the specified meal.

Review of resident #001's care plan showed they required assistance from staff for eating, and that staff were to ensure food was not left unattended with the resident when no staff were available to assist the resident with feeding. The care plan further showed resident #001 was at risk for choking and aspiration.

Review of video footage obtained from the home's Closed Circuit Television (CCTV) system from resident #001's RHA showed that on the above identified date, PSW #103 and RPN #106 delivered meal trays to resident #001's shared room at an identified time. RPN #106 immediately exited the room, and PSW #103 remained in the resident room for approximately two minutes. Over the course of the next 20 minutes several staff members entered and exited the resident room, none remaining in the room for greater than one minute. The meal trays were removed from resident #001's shared room approximately 20 minutes after service.

In interviews, PSWs #103 and #104 indicated that they were working on resident #001's RHA on the above identified date during the trial of room service at the specified meal. Neither PSW was able to identify who assisted resident #001 with feeding during that meal. PSW #103 indicated that resident #001 required assistance with feeding, though was able to self-feed at times. RPN #106 indicated that they were working on resident #001's RHA, and believed that resident #001 was assisted with feeding but was unsure who assisted the resident.

In an interview, DOC #101 indicated that when the resident's quarterly Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessments were carried out the highest level of assistance required would be selected, with the resident's care plan being built from the RAI-MDS assessment data. DOC #101 indicated that it was their understanding that resident #001 was able to assist with feeding at times, though was not aware that the resident's care plan indicated that food was not to be left unattended with resident #001 while no staff were available to assist the resident with feeding.

In an interview, the Administrator indicated that the home reviewed the video footage of the duration of meal service on resident #001's RHA and spoke with the staff who indicated that at the specified meal service on the identified date resident #001 was able to self-feed with set up assistance. The Administrator acknowledged that resident #001's

care plan indicated food was not to be left unattended with the resident while no staff members were available to assist the resident. The Administrator acknowledged that as no staff were present in resident #001's room for greater than two minutes at a time during the meal service that staff had not provided the care as per resident #001's plan of care related to feeding assistance. [s. 6. (7)]

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 with ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 17th day of June, 2020

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

Original report signed by the inspector.