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
Jul 29, 2021	2021_754764_0013	000235-21, 001998-21, 005182-21	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
Seniors Services and Long-Term Care (Union Station) c/o 55 John Street Toronto ON M5V 3C6

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

NAZILA AFGHANI (764)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 16, 17, 18, 21, 22, 23, 24, 25, 28 and 29, 2021.

The following intakes were completed in this Critical Incident System (CIS) inspection:
Log #000235-21, related to the fall prevention program.
Log #005182-21, related to a missing resident.

The following Compliance Order (CO) follow-up intake was inspected during this inspection:
Log #001998-21 related to restraints.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nurse Managers, Infection Prevention and Control (IPAC) Nurse Manager, Building Service Manager, Registered Practical Nurses (RPN), Registered Nurses (RN), Personal Support Workers (PSW), residents, and resident family members.

During the course of the inspection, the inspector conducted observations of IPAC practices in the home, staff and resident interactions and provision of care, reviewed resident health records, relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Infection Prevention and Control
Minimizing of Restraining
Nutrition and Hydration
Safe and Secure Home

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

- **3 WN(s)**
- **3 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 # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 29. (1)	CO #001	2020_610633_0029	764

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 O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature was measured and documented in writing, at a minimum in one resident common area on every floor of the home.

The home's Temperature & Humidex Record Tracking Sheets for two months, were reviewed. The temperature was not measured or documented at a frequency of once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night in one resident common area on every floor of the home.

The home's Temperature & Humidex Recording Tracking Sheets showed the temperature was recorded at 0800,1600 and 2200 hours in common areas, although it indicated gaps in measuring and documenting temperature once every morning, evening or night, in one resident common area on all seven floors.

The gap in temperature measurement and documentation was brought to the Building Service Manager's attention who acknowledged that the home's practice was not in accordance with the legislation.

Sources: The home's Temperature & Humidex Record Tracking Sheets for all areas, interview with Building Service Manager. [s. 21. (2) 2.]

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 that the temperature is measured and documented in writing, at a minimum in the following areas of the home: one resident common area on every floor of the home, which may include a lounge, dining area or corridor, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that two incidents in which a resident was missing for three hours or more were reported immediately to the Director.

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) related to resident #002, who was missing for more than 3 hours.

Resident #002 left the home on identified date and time, and returned to the home without injury after two days.

The home reported the resident missing via the MLTC after hours line on the following day.

The report was submitted to the Director after 18 hours.

A CIS report was submitted to the MLTC related to resident #003, who was missing for more than 3 hours.

Resident #003 left the home on identified date and time, and returned home without

injury after two days.

The home reported the resident missing via the MLTC after hours line on same day after 6 hours.

2. The licensee has failed to ensure an incident in which a missing resident who returned to the home with an injury or any adverse change in condition regardless of the length of missing time, was reported immediately to the Director.

A CIS report was submitted to the MLTC related to resident #004, who was missing for more than 3 hours.

Resident #004 left the home on identified date and time, sustained a physical injury; and returned home on the same day, after 9 hours.

The report was submitted to the Director after 5 hours and 23 minutes.

The Nurse Manager (NM) #113 verified that the incidents should have been reported immediately to the Director and home needed to provide additional education to registered staff.

Sources: CIS reports , Progress notes for residents #002, #003 and #004 and interview with NM #113. [s. 107. (1)]

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 that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4): a resident who is missing for three hours or more; and any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program when staff and essential visitors were not using the face shield within 2 meters of the residents.

Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007 Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7 with effective date of implementation: June 9, 2021, indicated that all staff and essential visitors are required to wear appropriate eye protection (e.g., goggles or face shield) when they are within 2 metres of a resident(s) as part of provision of direct care and/or when they interact with a resident(s) in an indoor area.

Inspector #764's observations during the inspection, showed that face shields or goggles were not in use within 2 meters of a resident in several observations.

All staff interviews showed that they were aware of requirement to use a face shield or goggles within 2 meters of a resident, but they failed to comply.

The DOC indicated it was expected that staff use a surgical/ procedure mask and face shield in units and resident areas.

The Infection Control Nurse Manager (ICNM) was made aware of the observations, they noted staff and essential visitors should use a face shield within 2 meters of a resident and IPAC (Infection Prevention And Control).

Sources: Directive #3 for Long-Term Care Homes, inspector #764's observations, interview with RPN #103, PSW #104, PSW #109, Housekeeper #111 and ICNM. [s. 229. (4)]

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 that staff and essential visitors are using face shield or goggles within 2 meters of the residents, to be implemented voluntarily.

Issued on this 3rd day of August, 2021

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

Original report signed by the inspector.