Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto Service Area Office
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Original Public Report

Report Issue Date October 19, 2022
Inspection Number 2022_1536_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
City of Toronto

Long-Term Care Home and City
Castleview Wychwood Towers, Toronto

Lead Inspector
Babitha Shanmuganandapala (673)

Additional Inspector(s)
Rajwinder Sehgal (741673)

Inspector Digital Signature
Rajwinder Sehgal
Digitally signed by Rajwinder Sehgal
Date: 2022.11.01 15:37:34 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): September 29, and 30, 2022; and October 3, 4, 5, and 14, 2022.

The following intake(s) were inspected:

- Intake #00001146 (CIS #M510-000008-22, related to fall prevention and management
- Intake #00001848 (CIS #M510-000003-22) related to resident-to-resident physical abuse
- Intake #00004175 (CIS #M510-000013-21), related to fall prevention and management

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION [DIRECTIVES BY MINISTER]

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

Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that every operational or policy directive issued by the Minister that applies to the long-term care home is carried out.

a) The Minister's Directive: COVID-19 response measure for long-term care homes, section 1.1, requires homes to develop and implement a COVID-19 Outbreak Preparedness Plan which includes conducting regular IPAC audits in accordance with the COVID-19 Guidance Document for Long-Term Care Homes in Ontario.

The guidance document states that homes must complete IPAC audits every two weeks unless in outbreak. When a home is in outbreak IPAC audits must be completed weekly. At minimum, homes must include in their audit Public Health Ontario's "COVID-19: Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes", and the audits should be rotated across shifts, including evenings and weekend.

Of the IPAC audits conducted from July to September, 2022, all of them were conducted during weekday shifts, and none were completed during evenings or weekends.

The home was in a COVID-19 outbreak from June 20, to August 14, 2022, and an IPAC audit was not conducted during the week of July 24th to 30th, 2022.

The home was in a COVID-19 outbreak from August 26 to September 9, 2022, and IPAC audits were not completed between September 10 and September 30, 2022.

b) Section 1.2 of the Minister's Directive, requires licensees to ensure that masking requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario are followed.

Homes were required to ensure that all staff, students, volunteers and visitors wear a medical mask for the entire duration of their shift or visit indoors. Homes must ensure that all staff comply with masking requirements at all times, even when they are not delivering direct patient care, including in administrative areas. During their breaks, to prevent staff-to-staff transmission of COVID-19, staff must remain two metres away from others at all times and be physically distanced before removing their medical mask for eating and drinking.

A Volunteer was noted to be coming off an elevator with another staff member wearing

their mask only over their mouth, and not covering their nose. A Personal Care Aide (PCA) was seen not wearing a mask while in the elevator with other staff members. They stated that their mask had gotten wet, so they had removed it.

A Registered Practical Nurse (RPN) was observed in an administrative area to not be wearing a mask while sitting less than two meters away from another staff member.

The three above mentioned individuals acknowledged they should have been wearing their masks as appropriate.

Failure to ensure staff followed mandatory masking requirements and complete IPAC audits increased the risk of transmission of infection.

Sources: Observations conducted on September 29, and October 4, 2022, home's IPAC audits, interview with the IPAC Lead, Volunteer #113, PCA #100 and RPN #116; The Minister's Directive: COVID-19 response measure for long-term care homes, COVID-19 Guidance Document for Long-Term Care Homes in Ontario
[673]

WRITTEN NOTIFICATION [PLAN OF CARE- RESPONSIVE BEHAVIOURS]

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

Non-compliance with: O. Reg. 79/10, s. 26 (3) 5.

The licensee has failed to ensure that resident #001's plan of care was based on an interdisciplinary assessment of their mood and behaviour patterns and potential behavioural triggers.

Over a four-month period, resident #001 had eight altercations of a verbal and physical nature, with resident #002.

Staff stated that the interventions directed staff to closely monitor and redirect resident #001; however, this was not always effective.

Referrals were made to the Behavioural Support Ontario (BSO) team on an identified date and a response from the BSO team was completed. Recommendations were made to manage resident's #001 responsive behaviours. Resident #001 was also assessed by the Geriatric Mental Health Outreach Team (GMHOT) at this time, but the home was waiting for the consultation notes.

Resident #001 physically abused resident #002 on an identified date, at which time another BSO referral was made. The referral was not addressed by the BSO team until a week later. The BSO team documented they would follow up with the GMHOT consultation.

Resident #001's written plan of care was not updated until the date of abuse to reflect their behaviors and interventions.

The BSO Lead stated that the BSO team should have followed up on the referrals within three days, followed up with the GMHOT consultation notes sooner and updated resident #001's plan of care related to behaviours, triggers and interventions.

Sources: Resident #001 and #002's medical records, written plan of care and progress notes; interview with PCA #101, RPN #106, RPN #103, BSO Lead, home's Critical Incident Report
[673]

WRITTEN NOTIFICATION [DUTY TO PROTECT]

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 19 (1)

The licensee has failed to ensure that resident #002 was protected from abuse by resident #001.

On an identified date, resident #001 entered resident #002's room and threatened resident #002. PCA #101 stated they witnessed resident #001 making these threats, so they intervened and de-escalated the situation.

On an identified date, resident #001 entered resident #002's room and struck resident #002. Resident's #002 was sent to the hospital for treatment of an injury.

Sources: Resident #001 and #002's medical records and progress notes, interview with PCA #101 and resident #003, home's Critical Incident Report
[673]

WRITTEN NOTIFICATION [ALTERCATIONS AND OTHER INTERCATIONS BETWEEN RESIDENTS]

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 54 (b)

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #001 and resident #002 by identifying and implementing interventions.

Over a period of four-months, resident #001 had eight altercations with resident #002. Resident #001's behaviours were difficult to alter, and staff needed to separate the residents for safety. During the last altercation, resident #001 struck resident #002 resulting in an injury.
PCA #101, and RPN #106 stated that the interventions in place to manage resident's #001 behaviours were not always effective.
RPN #103 and the BSO Lead stated that if a resident had repeated altercations with another resident, the intervention would be to move one of their rooms. RPN #106 stated that this intervention was identified by the team but was never implemented until the eighth altercation.

Failure to implement the intervention of changing rooms for the residents led to further altercations between resident #001 and resident #002, causing harm to resident #002.

Sources: Resident #001 and #002's medical records and progress notes; interview with PCA #101, RPN #106, RPN #103, BSO Lead, and resident #003; home's Critical Incident Report
[673]

WRITTEN NOTIFICATION [REPORTS RE CRITICAL INCIDENTS]

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O.Reg. 246/22, s. 115 (1) 5.

The licensee has failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances, of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Posters indicating a suspected outbreak of COVID-19 were observed throughout the home on October 4, 2022. The home was informed by Public Health to be in a Rhinovirus outbreak on October 5, 2022.

The disease outbreak was not immediately reported to the Director via the Critical Incident System as required.

Sources: Observations conducted on October 4, 2022, interview with the DON, MLTC's reporting records
[673]

WRITTEN NOTIFICATION [PLAN OF CARE]

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6 (10) (b)

The licensee shall ensure that a resident was reassessed, and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs changed.

The resident had a history of falls and was assessed by the Occupational Therapist (OT). A fall prevention intervention was recommended by the OT and implemented by staff.

The intervention was not initiated in the resident's care plan until after ten months from the date of recommendation. Nurse Manager #109 stated the home provided this specific intervention to the resident, and the nursing team should have updated the care plan with this specific intervention.

Failure to ensure that a resident's care plan is up to date may result in an increase in the risk of falls and delay in staff responding to care needs

Sources: Resident #005's care plan, progress notes, April 2022 POC record, OT progress notes, interviews with RPN #126, Nurse Manager #109, PCA #127, and RAI RN lead #108.
[741673]

WRITTEN NOTIFICATION [PLAN OF CARE]

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in one resident's plan of care was provided to the resident as specified in the plan.

A resident was assessed at risk for falls and had a history of falls. Their written plan of care for falls prevention directed staff to provide two interventions while the resident was in bed.

The resident was observed lying in their bed without the interventions in place.

According to staff, the resident required the interventions for fall prevention and management, and acknowledged the interventions were not provided.

Nurse Manager #109 acknowledged that resident's plan of care was not followed.

Failure to ensure the plan of care for falls prevention for the resident was provided, placed the resident at risk for falls and potential injury.

Sources: Resident #004's care plan, progress notes, OT progress notes, interviews with RPN #125, Nurse Manager #109, and PSW #123
[741673]

WRITTEN NOTIFICATION [PLAN OF CARE]

NC#008 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (10) (b)

The licensee failed to ensure that one resident was reassessed, and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs changed.

A resident had a history of falls and was assessed by the OT on an identified date. Interventions were recommended as falls prevention strategies and the interdisciplinary team decided to implement these strategies.

One of the interventions were not initiated in the care plan until five months after the recommendation was made, while the other recommendation was never initiated. Nurse Manager #109 stated that the nursing team was responsible for updating the care plan to reflect the above-mentioned interventions.

By not having the required interventions in place for mitigating injury or assisting in falls prevention, the risk of the resident sustaining a fall was increased.

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Sources: Resident #004's care plan, progress notes, OT progress notes, interviews with RPN # 115, Nurse Manager # 109, PCA #124, and PCA #123.
[741673]