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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Toronto, ON, M2M 4K5
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Original Public Report

Report Issue Date: May 9, 2023

Inspection Number: 2023-1536-0003

Inspection Type:
Complaint
Critical Incident System

Licensee: City of Toronto

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

Lead Inspector	**Inspector Digital Signature**
Manish Patel (740841)	Manishkumar C Patel Digitally signed by Manishkumar C Patel Date: 2023.05.10 10:03:17 -04'00'

Additional Inspector(s)
Oraldeen Brown (698)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 17 - 21, and 24 - 26, 2023
The inspection occurred offsite on the following date(s): April 27, 2023

The following intakes were completed in this Critical Incident (CI) inspection:
- Intake: #00019454 - [CIS #M510-000004-23] regarding written complaint about care.
- Intake: #00019655 - [CIS #M510-000005-23] regarding missing resident.

The following intakes were completed in this complaint inspection:
- Intake: #00021328 - regarding IPAC practices and housekeeping.
- Intake: #00084203 - regarding neglect, falls prevention and management, pest control, continence care and bowel management, skin and wound care.

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

Resident Care and Support Services
Continence Care
Skin and Wound Prevention and Management

Housekeeping, Laundry and Maintenance Services
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 79 (1) 9.

The licensee has failed to use proper techniques to assist a resident with eating, including safe positioning of the resident who required assistance.

Rationale and Summary
On an identified date, a resident was observed sitting at the dining table in an unsafe position while having their meal. Staff confirmed that the resident was not sitting safely, while eating as all residents needed to sit in certain position while eating to be safe. Staff corrected the position, with which, the resident was then sitting in safe position for eating.

Sources
Observation; Interview of the staff; Review of the Policy titled 'Care of Residents with Swallowing Difficulties' numbered as RC-0523-14, published on January 1, 2019. [740841]

Date Remedy Implemented: April 25, 2023

WRITTEN NOTIFICATION: Specific Duties Regarding Cleanliness and Repair

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)

The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Summary and Rationale
(1) On April 19, 20 and 25, 2023, strong sewer-like odours were noted emanating from the ground floor servery. This odour was also noted at various areas on the main floor including upon entry into the home, inside the main floor lobby where screener is located, on the sixth floor near the C side elevator, and inside tub room number four on floor six, West wing.

Tub room number four on floor six, West wing, did not appear to be in use as they were filled with boxes and other objects stashed inside a jacuzzi.

Residents and staff acknowledged that they reported concerns regarding the odours inside the home.

IPAC lead, RPN and Building Service Manager acknowledged that they were aware of the odors themselves.

RPN, Health and Safety Committee member, acknowledged that they informed the building manager a month prior.

Failure to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odors put residents at risk for reduction in their quality of life.

Sources: observations, plumbing work log receipts, interviews with BSM and other staff. [698]

(2) On April 18, 2023, damaged surfaces including walls, floors and door frames and were noted in the following areas of the home:

Washrooms number two on floor six, West wing: The flooring condition in the large toilet section to the left of the shower room was in disrepair. The colouring on the floor was worn off.

There were black marks and build-up were noted on the textured floor surfaces and along extended floor surfaces in the hallways.

Washrooms number three on floor six, West wing: The tub room area had an uncovered drainage hole which was later covered after being addressed with the Building Services Manager (BSM). The room had a strong septic odor coming from the sewage/drainage hole in the ground. Empty boxes were stored in the Jacuzzi tub which had dirty stains on the ledge of the tub.

Washrooms number three on floor six, West wing: The toilet area had a closed off hole in the wall with a metal covering clued over it. There were dried glue drippings along the base of the wall.

Washroom number four on floor six, West wing: The toilet and sink area was unkept and in disrepair. The toilet cubicles had no privacy curtains or door. There were major dents on the outer aspects of the metal cubicle divider. The colouring on the floor was worn off.

One resident room on floor six, West wing had urine stains on the floor with extensive buildup of dust mites. On April 25, 2023, the housekeeping mopped the center of the floor and avoided the corners of the room. After the floor was dried, the inspector showed the housekeeper the areas stained with urine and dust mites. They proceeded to clean it after it was pointed out. The BSM acknowledged that floor cleaning condition was inadequate.

On April 19, 2023, another identified resident's room on floor six, West wing had a device used by labs observed on the floor at the foot of the bed as well as other debris on the floor underneath the nightstand in the same room. This was pointed out to a housekeeper and remained there until the following day when the inspector took the BSM up to the unit to show them.

There were three identified door frames to resident rooms had damages and missing panels.

The failure to maintain a clean environment and required repairs of the home, compromised the long-term care home's ability to provide a livable environment for residents.

Sources: Observations, interviews with Building Service Manager and other staff. [698]

WRITTEN NOTIFICATION: Complaints Procedure

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee has failed to immediately forward to the Director a written complaint, concerning the care of a resident.

Rationale and Summary
A written complaint was received by the licensee, concerning the care of a resident. The Director was informed of this written complaint after a number of days. Policy, AD-0515-00, titled 'Managing and Reporting Complaints', published on January 7, 2022, identified to immediately report to the Director of any written complaint that licensee received concerning the care of a resident.

Staff said that the complaint was received by them on identified date, and stated that the complaint was required to be reported to the Director immediately, but was reported late.

Sources
Interview with Staff, review of Critical Incident System Report and Policy AD-0515-00 titled Managing and Reporting Complaints; published on January 7, 2022. [740841]

WRITTEN NOTIFICATION: Dining And Snack Services

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.

The licensee has failed to use proper technique to assist a resident after eating, including sitting safely in certain position for identified period of time after meals.

Rationale and Summary
As per the care plan, the resident required to be sitting in certain position for identified period of time after meals. In an interview with staff, the staff stated that the resident should be sitting in a certain position after their meal if that was in the care plan.

When resident was observed after finishing their meal, the resident was not in the correct sitting position as per the care plan.

In an interview, the staff, stated that the resident's care plan indicated to keep the resident in certain position for identified period of time. At the time of interview, the staff stated that the resident needed to be in certain position to prevent injuries as per the care plan.

After an interview, the staff immediately brought the resident in safe position.

Not keeping resident in certain position after meals increased the risk of injuries to the resident.

Sources
Observation; Interview of the staff; Review of the resident Care plans. [740841]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)

The licensee has failed to ensure that all staff participate in the implementation of the Infection Prevention and Control (IPAC) program, specifically for indoor mandatory masking, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead.

Rationale and Summary
On April 25, 2023, Registered Practical Nurse (RPN) was observed walking on the main floor without wearing a mask. The signages inside the home indicated that a mask was required.

On April 26, 2023, a second incident occurred during an interview with the DOC. The DOC removed their mask during the interview and asked the inspector whether they can keep their mask off while social distancing during the interview. The inspector advised the DOC that it would be best to continue practicing the directives while the interview was being conducted. The DOC removed one ear loop of their mask at least twice throughout the interview.

The RPN acknowledged they were not wearing the required PPE while inside the home and that they removed their mask due to it being compromised. The RPN confirmed that they should be wearing a mask while inside the home.

The IPAC lead acknowledged that mask was required by everyone while inside the home.

Sources: Observations on April 25, 2023; interviews with RPN, DOC and IPAC Lead; review of IPAC Standards. [698]

WRITTEN NOTIFICATION: Dealing With Complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

The licensee has failed to ensure that the written response to a complaint, provided to a person who made a complaint to the licensee concerning the care of a resident, included the Ministry's toll-free

telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary
A Critical incident report was submitted to the Director. According to this report, a written complaint was received by the licensee on certain date, which was concerning the care of a resident.

The complaint was responded with a written response letter. The letter did not have the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010. Absence of this information in the response letter was also confirmed by the staff.

Sources
Interview with Staff, review of complaint response letter dated January 23, 2023. [740841]

WRITTEN NOTIFICATION: Dealing With Complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. iii.

The licensee has failed to ensure that the written response, provided to a person who made a complaint to the licensee concerning the care of a resident included information that the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, and confirming that the licensee did so.

Rationale and Summary
A Critical incident report was submitted to the Director. According to this report, a written complaint was received by the licensee on identified date which was concerning the care of a resident.

The complaint was responded with a written response letter. The letter did not have information that the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, and confirmation that the licensee did so. Absence of this information in the response letter was also confirmed by the staff.

Sources
Interview with Staff, review of complaint response letter. [740841]

WRITTEN NOTIFICATION: Reports Regarding Critical Incidents

NC #008 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 of an outbreak of a disease of public health significance.

Rationale and Summary
An outbreak was declared by Public Health while the critical incident report to the Director for this outbreak was submitted days after it was declared by Public Health. In an interview with the staff, they confirmed that this was late reporting.

Not communicating an outbreak of a disease of public health significance, decreased the Director's abilities to respond to threats to the health of residents, staff, volunteers and visitors.

Sources
Interview of staff, Critical Incident System report. [740841]