Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: December 6, 2023

Inspection Number: 2023-1536-0005

Inspection Type:
Complaint
Critical Incident

Licensee: City of Toronto

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

Lead Inspector	**Inspector Digital Signature**
Slavica Vucko (210)	

Additional Inspector(s)
Ryan Randhawa (741073)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 3, 6, 7, 8, 9, 10, 14, 15, 16, 17, 20, 21, 22, 23, 24, 2023
The inspection occurred offsite on the following date(s): November 29, December 4, 2023

The following intakes were completed in this Critical Incident (CI) inspection:
- Intake: #00089161, related to injury sustained by a resident of unknown cause
- Intake: #00090495, intake #00094686, intake #00096140, intake: #00096140 related to an injury with a significant change in condition
- Intake: #00097127, #00022234, #00084275, related to COVID-19 outbreak

The following intakes were completed in this Complaint inspection:

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- Intake: #00098464, complaint related to personal support services, infection prevention and control (IPAC) and hospitalization
- Intake: #00099950, complaint to change in health condition and hospitalization.
- Intake: #00101140, complaint related to skin issues, dining and snack service, change in health condition and transfer to hospital.

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Involvement of resident, etc.
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that the resident's substitute decision-maker (SDM), and any other persons designated by resident #002 were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and summary

A complaint was submitted to the Ministry of Long Term Care (MLTC) by resident #002's SDM, that the SDM was not informed about resident #002's new signs and symptoms of a health status change for a specified time period before hospitalization.

A review of resident #002's clinical record indicated that for a specific time period the resident presented with few episodes of new signs and symptoms that were treated. As per the interview with staff the registered staff had to inform the family members or SDM about changes in a resident's health status. Registered staff did not inform resident #002's family member about new signs and symptoms the resident was experiencing because they were temporary and resolved. The resident's family member was contacted when the symptoms became significant.

As per the home's policy if a specific symptom was present, the home should involve and educate resident's SDM on the treatment plan.

Interview with staff indicated that if resident #002's SDM was informed about their new signs and symptoms before the hospitalization they would have had opportunity to participate in their care planning.

Failure of staff to inform resident #002's SDM about the resident's new signs and symptoms for a specified period before hospitalization, lead to the SDM inability to

participate fully in the development and implementation of the resident's plan of care.

Sources: review of resident #002's clinical record, home's policy Pain Assessment and Management #RC-0518-01 dated January 02, 2020, interview with resident #002's SDM, home's staff Registered Practical Nurses (RPNs), Registered Nurses (RNs), and other staff.
[210]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Documentation,
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of the care set out in the plan of care for resident #004 was documented correctly.

Rationale and Summary

A complaint was submitted to the MLTC that the resident was not provided proper care with falls prevention. Resident #004 was at risk for falls and sustained a fall on a specified date.

Resident #004's care plan indicated that they required a specific level of assistance for transferring. Resident #004's documentation indicated that during a specified

time period staff documented that they provided the resident with a specific assistance for transfers not coinciding with their care plan.

Personal Support Workers (PSWs) indicated that resident #004 required a specific level of assistance for transfers. It was acknowledged by staff that the resident was provided with the correct level of assistance for a specified time period but the documentation did not reflect the same.

Staff failure to document correctly the provision of care set out in the plan of care for resident #004 lead to minimal risk to the resident but could potentially have a negative impact on future care plan revisions and updates.

Sources: review of resident #004's clinical record, interviews with home's staff . [741073]

WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Binding on licensees
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every Minister's Directive that applied to the long-term care home, the Minister's Directive was complied with.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, the licensee was required to ensure

that the masking requirements set out in the COVID-19 guidance document for long-term care homes in Ontario, effective November 07, 2023, were complied with.

Rationale and Summary

The COVID-19 guidance document for long-term care homes in Ontario, effective November 07, 2023, directed the homes that masks were required to be worn indoors in all resident areas by all staff, students, volunteers and support workers.

Observation in a home area, indicated a staff member was not wearing a mask when being in close proximity of a resident.

The IPAC Lead acknowledged that the staff should have been wearing a mask when serving the residents.

Failure of the staff to wear a mask, as required by the COVID-19 guidance document for long-term care homes in Ontario, could increase the risk for transmission of communicable disease.

Sources: observations; Minister's Directive: COVID-19 response measures for long-term care homes (August 30, 2022); COVID-19 guidance document for long-term care homes in Ontario (November 07, 2023), and interviews with IPAC Lead and other staff.
[741073]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 3.

s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
3. Monitoring of all residents during meals.

The licensee has failed to ensure that the home had a dining and snack service that included, at a minimum, monitoring of all residents during meals.

Rationale and summary

A complaint was submitted to the MLTC regarding resident #003 who had an incident during meal while not being supervised and required treatment.

The written plan of care for resident #003 indicated they required supervision with eating.

On the day of the incident the resident was served their meal in bed and left alone to eat. The resident presented with signs and symptoms that required immediate attention and treatment by staff. The resident was attended by registered staff and provided emergency care. As per the interview with staff resident #003 was able to reposition their bed to an angle that was not safe for them while eating.

Resident #003 was not supervised when they were eating in their room alone which placed them at risk of harm.

Sources: review of resident #003's clinical record, interview with resident #003's family, and home's staff .
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WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The licensee has failed to ensure that resident #004 was provided with personal assistance required to safely eat and drink.

Rationale and Summary

Observation indicated a staff member left a texture modified beverage with eating assistive device in resident #004's room. The staff left the room and resident #004 consumed the beverage on their own.

Resident #004's care plan indicated that they had a specific health condition that required assistance with eating and drinking. The staff did not provide the required level of assistance.

Failure of the home to ensure that resident #004 was provided with personal assistance required for eating and drinking could place the resident at risk.

Sources: observations; review of resident #004's clinical record; interviews with home's staff.
[741073]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure the implementation of a standard issued by the Director with respect to infection prevention and control (IPAC). The home has failed to ensure that Routine Practices were implemented in accordance with the "IPAC Standard for Long-Term Care Homes April 2022". Specifically, hand hygiene, including the four moments of hand hygiene, as required by Additional Requirement 9.1 (b) under the IPAC standard.

Rationale and Summary

A staff member was observed assisting multiple residents with an activity of daily living. The staff did not perform hand hygiene when contacting multiple residents and their belongings. The staff acknowledged that they should have performed hand hygiene between contact with the different residents.

The IPAC Lead acknowledged that the staff expectation was to perform hand hygiene before and after contact with the different residents.

Failure staff to perform hand hygiene, following the four moments of hand hygiene

between residents interaction could increase the risk of infection transmission.

Sources: observations; review of “IPAC Standard for Long-Term Care Homes April 2022”; interviews with the IPAC Lead and other staff.
[741073]