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

Original Public Report

Report Issue Date: March 26, 2024

Inspection Number: 2024-1536-0001

Inspection Type:
Complaint
Critical Incident

Licensee: City of Toronto

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

Lead Inspector	**Inspector Digital Signature**
Oraldeen Brown (698)	Oraldeen Brown Digitally signed by Oraldeen Brown Date: 2024.04.16 09:20:42 -04'00'

Additional Inspector(s)
Goldie Acai (741521)
Nrupal Patel (000755)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 12, 13, 14, 15, 16, 20, 21, 22, 2024

The following Critical Incident System (CIS) intake(s) were inspected:

- Intake: #00100954, CIS #M510-000037-23; #00104754, #M510-000043-23 and #00107557, #M510-000004-24 related to allegations of abuse.
- Intake: #00102646, #M510-000041-23; #00106216, #M510-000002-24; and #00107928, #M510-000008-24 related to outbreaks.

The following complaint intake was inspected:

- Intake: #00106694 related to allegations of neglect.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
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)

Plan of care

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 a resident's substitute decision-maker (SDM), and any other persons designated by the resident or SDM were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary

A resident was assessed by the Physiotherapist (PT) post fall. The PT initiated an intervention of utilizing an assistive device in addition to their existing device for the resident. The PT confirmed that the initiated intervention was not discussed with the resident's Power of Attorney (POA) or SDM before it was implemented by the home.

Failure to provide the POA or SDM the opportunity to participate fully in the

development and implementation of a resident's plan of care requirements increased the risk that the resident's wishes for their own care were not respected or carried out.

Sources: Interview with PT and review of the resident's care plan and progress notes.
[741521]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

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

Rationale and Summary
A resident sustained an injury and was transferred to a hospital, resulting in a significant change in the resident's health status.

The inspector observed the resident lying in bed with the bed in an incorrect position. A second specific fall intervention was noted absent.

The resident's plan of care indicated to keep their bed in an identified position and the second fall intervention to be in place when in bed.

A Personal Worker (PSW) acknowledged that the specified fall interventions

should be in place while the resident was in bed during the above mentioned observation.

Failure to follow the resident's plan of care and ensure fall interventions were in place posed a safety risk.

Sources: Long-Term Care Home's (LTCH's) investigation files, CIS # M510-000004-24, observation of resident, review of resident's clinical health records, interviews with a PSW and other relevant staff.
[698]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to ensure that a resident was reassessed and the plan of care revised when the resident's care needs changed.

Rationale and Summary
A resident was in their room when an individual arrived requesting to speak to them.

The resident stated that staff allowed the individual to enter their space without providing any support or warning. The resident stated the actions of the individual

startled and traumatized them. A PSW stated the resident's behavior was altered post incident. After the incident, the resident spoke to the Director of Nursing (DON) and requested that in future, should the individual request to speak to them, that staff would be present during the interaction.

The DON acknowledged that the plan of care was not updated to reflect the resident's request.

Failure to update the resident's plan of care put them at risk of not receiving requested care.

Sources: Interviews with the resident, PSW, and DON; record review of resident's plan of care and progress notes; and observations of resident.
[741521]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1)
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the

Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.
(5) The following persons are guilty of an offence if they fail to make a report required by subsection (1):
1. The licensee of the long-term care home or a person who manages a long-term care home pursuant to a contract described in section 113.
2. If the licensee or person who manages the home is a corporation, an officer or director of the corporation.
3. In the case of a home approved under Part IX, a member of the committee of management for the home under section 135 or of the board of management for the home under section 128 or 132.
4. A staff member.
5. Any person who provides professional services to a resident in the areas of health, social work or social services work.
6. Any person who provides professional services to a licensee in the areas of health, social work or social services work.
(6) Every person mentioned in paragraph 1, 2, 3 or 4 of subsection (5) is guilty of an offence if the person,
(a) coerces or intimidates a person not to make a report required by this section;
(b) discourages a person from making a report required by this section; or
(c) authorizes, permits or concurs in a contravention of the duty to make a report required by this section.
(7) Nothing in this section abrogates any privilege that may exist between a solicitor and the solicitor's client.

The licensee failed to ensure that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident was immediately reported to the Director.

Rationale and Summary
A resident reported to the Behavioral Support Ontario (BSO) staff that a resident had

spoken to them in a sexual manner. The BSO staff provided this information to the unit nurse and the DON. A staff reported the resident appeared visibly distressed and emotional after the interaction with co-resident.

The DON stated the report should have been made to the Director 'right away' when staff at the home were informed.

Failure to immediately report allegations of abuse to the Director increased the risk of delayed follow up actions.

Sources: Interview with the resident, RN and the DON; record review of the resident's progress notes, and the home's policy titled, 'Zero tolerance of abuse and neglect' #RC-0305-00, published January 6, 2021.
[741521]

WRITTEN NOTIFICATION: General Requirements

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented for a resident.

Rationale and Summary
A resident sustained altered skin integrity and required transfer to a hospital for

further assessment.

Record review indicated there was no documentation of a skin/ wound assessment completed prior to the resident being transferred to the hospital.

The RN acknowledged that they did not complete a skin/wound assessment for the resident. The Nurse Manager (NM) acknowledged that no skin/ wound assessment was completed for the resident by RN prior to being transfer to the hospital.

Failure to document resident assessments may have contributed to delayed identification of injury.

Sources: LTCH's investigation files, CIS # M510-000004-24, resident's clinical health records, interviews with the RN and other relevant staff.
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WRITTEN NOTIFICATION: Transferring and Positioning

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary
A resident was discovered with altered skin integrity which became more prominent after a few days. The resident was sent to the hospital for further assessment and

returned to the home with a diagnosis of an injury.

The home's investigation notes revealed that an agency staff verified that they had independently transferred the resident while providing care.

The DON acknowledged that safe transferring and positioning technique was not used during transfer for the resident.

Failure to perform safe transfer and positioning techniques put the resident at risk of injury.

Sources: LTCH's investigation files, CIS # M510-000004-24, resident's clinical health records, interviews with the DON and other relevant staff.
[698]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (2)
Reports re critical incidents
s. 115 (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 246/22, s. 115 (2).

The licensee has failed to report a critical incident after normal business hours using the Ministry's method for after-hours emergency contact.

Rationale and Summary
A COVID-19 outbreak was declared by the Public Health Unit (PHU) on a home area

and a Critical Incident System (CIS) report was submitted by the home after normal business hours to the Director. The home did not use the Ministry's method for after-hours emergency contact.

The Ministry of Long-Term Care (MLTC) Reporting Requirements - reference sheet sent out on August 18, 2023, indicated that for critical incidents report immediately outside of business hours, to call the Service Ontario After Hours Line.

A Nurse Manager (NM) acknowledged that the home submitted a CIS but did not call the Service Ontario After-Hours Line.

Failure of the home to immediately report the incident could have delayed the Director's ability to respond to the incident in a timely manner.

Sources: Review of CIS #M510-000002-24; MLTC Reporting Requirements - reference sheet; interview with the Nurse Manager.
[000755]

WRITTEN NOTIFICATION: Reports Re: Critical Incidents

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.
The licensee has failed to ensure that the Director was immediately informed of a

fall that caused an injury to a resident for which the resident was taken to the hospital and resulted in a significant change in the resident's health condition.

Rationale and Summary
A resident had a fall that resulted in the resident being taken to the hospital where they were diagnosed with injuries.

The DON confirmed a critical incident report was to be submitted to the Director but was not done for this incident.

Failure to report to the Director increased the risk of delayed follow up actions.

Sources: Interview with DON, Falls lead; record review of resident's progress notes, LTCHomes.net.
[741521]