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: August 26, 2024

Inspection Number: 2024-1536-0004

Inspection Type:
Critical Incident
Follow up

Licensee: City of Toronto

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 15-19, 23-26, 29-31, 2024

The following intake(s) were inspected in this Follow Up inspection:

- Intake: #00118005 - duty to protect

The following intake(s) were inspected in this Critical Incident (CI) inspection:

- Intake: #00113206 [CI: M510-000021-24] - related to abuse
- Intake: #00117688 [CI: M510-000031-24] - related to a fall
- Intake: #00119379 [CI: M510-000034-24] - related to allegations of neglect associated with a fall and continence care and bowel management

The following intake(s) were completed in this CI inspection:

- Intakes: #00116343 [CI: M510-000026-24], #00117147 [CI: M510-000028-24], #00117830 [CI: M510-000032-24], #00121223 [CI: M510-000037-24] - related to a fall

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1536-0003 related to FLTCA, 2021, s. 24 (1) inspected

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
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:
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.

The licensee has failed to ensure that when a staff had reasonable grounds to

suspect abuse of a resident to immediately report the suspicion and the information upon which it was based to the Director.

Rationale and Summary
A Recreation Services Assistant (RSA) allegedly witnessed abuse by a Personal Support Worker (PSW) towards multiple residents on a resident home area. The incidents were reported to the home the next day and was subsequently reported to the Director.

A Nurse Manager (NM) verified that the staff did not immediately report the incident to the home and that it was reported the next day after the incident had occurred. Furthermore, two identified NMs both confirmed it was expected for staff to immediately report any suspicion of abuse of a resident.

Failure to immediately report the suspicion of abuse of a resident could lead to the delay in response by the licensee and Ministry of Long-Term Care (MLTC).

Sources: CI Report; Interviews with RSA and NMs.

COMPLIANCE ORDER CO #001 Plan of Care

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:
1) Provide education to two PSWs on residents' plan of care who require a specific type of continence care and a certain level of assistance with transfers.

2) Maintain a record of the education including staff signed attendance, the date of the education, and name of the staff member who provided the education.

3) Conduct weekly audits of two PSWs for three weeks:
(i) on providing care to residents who require a specific type of continence care, and
(ii) for residents who require a certain level of assistance for transfers.

4) Maintain a record of audits conducted, including staff and resident who were audited, the name of the auditor, time and dates of the audit, results of the audit, and any actions taken to address the audit findings.

Grounds
The licensee has failed to ensure that the care set out in the plan of care related to continence care and transfers were provided to two residents as specified in their plan by two PSWs.

Rationale and Summary

(i) A resident had a fall with injury during the provision of continence care.

The resident's plan of care at the time of the fall indicated that they had specific care requirement for continence care. A review of the home's internal investigation indicated that a PSW had provided a different method of continence care from what was specified in the resident's plan of care at the time of the fall.

A Registered Nurse (RN) verified that the resident required a specific care requirement for continence care. An NM confirmed that the PSW did not follow the resident's plan of care.

Failure to ensure that the resident was provided the care set out in the plan of care related to continence care led to the fall with injury.

Sources: A resident's clinical records; Home's internal investigation; Interviews with RN and NM.

(ii) A resident's plan of care indicated that the resident required a certain level of assistance with a transferring device for transfers. However, a review of the home's internal investigation indicated that a PSW transferred the resident without the use of a transferring device.

The PSW acknowledged that a transferring device should have been used for the resident during the transfer. An RN verified that the resident required a transferring device for transfers. An NM confirmed that the PSW did not follow the resident's plan of care related to transfers.

Failure to ensure that the resident was transferred with a certain level of assistance using a transferring device as specified in their plan posed a risk to the resident's safety.

Sources: A resident's clinical records; Home's internal investigations; Interviews with a PSW, an RN, and an NM.

(iii) A resident's plan of care indicated they required a certain level of assistance with transfers and provision of care with continence care.

A review of the home's internal investigation notes indicated that a PSW had transferred a resident by a certain level of assistance that was not specified in their plan of care. The PSW confirmed that they were aware of the resident's requirement for assistance with transfers as per their plan of care, but had transferred the resident by a different method. An NM confirmed that the PSW did not follow the resident's plan of care when they transferred the resident.

Failure to follow the resident's plan of care poses a risk of injury.

Sources: CI Report; A resident's clinical records; Home's internal investigation; Interviews with PSW and NM.

This order must be complied with by October 4, 2024

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Long-Term Care Inspections Branch

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.