Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 26, Nov 21, 2017	2017_626501_0020	023940-17	Resident Quality Inspection

Licensee/Titulaire de permis

City of Toronto
55 JOHN STREET METRO HALL, 11th FLOOR TORONTO ON M5V 3C6

Long-Term Care Home/Foyer de soins de longue durée

TRUE DAVIDSON ACRES
200 DAWES ROAD TORONTO ON M4C 5M8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SUSAN SEMEREDY (501), DEREGE GEDA (645)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 16, 17, 18, 19, 20 and 23, 2017.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Nurse Manger, registered nursing staff, Personal Care Attendants (PCAs), Social Workers (SW), Building Services Manager (ESM), City of Toronto Security Lead for Long-Term Care Homes, Substitute Decision Makers (SDMs), Residents' Council President, Family Council Representative, family members and residents.

During the course of the inspection the inspectors conducted a tour of the home; observed medication administration, resident to resident interactions, staff to resident interactions and the provision of care; reviewed resident health care records, meeting minutes for Residents' Council, relevant policies and procedures and video surveillance.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee has failed to ensure that resident #001's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity was fully respected and promoted.

Resident #001 triggered for dignity lacking from stage one of the inspection from a resident interview by indicating that staff do not always help him/her as needed with an identified Activity of Daily Living (ADL). Further interview with resident #001 revealed PCA #107 told the resident to put on his/her an identified piece of clothing. Resident #001 stated he/she was upset about the incident because he/she cannot put on the identified piece of clothing and told RN #106 about the incident.

Record review revealed resident #001 was admitted to the home on identified date. Review of resident #001's plan of care on the identified date, indicated the resident needs extensive assistance for most Activities Daily Living (ADLs) related to various medical conditions. For an identified ADL, the written plan of care states extensive assistance is needed and one staff is to assist.

Interview with RN #106 revealed he/she recalled overhearing resident #001 talking to his/her family complaining that PCA #107 told resident #001 to perform an identified ADL. RN #106 revealed he/she talked to the family and tried to apologize and also reported the incident to management.

Interview with the DOC revealed he/she remembered investigating the above mentioned incident. Review of the home's investigation notes revealed that the incident occurred on an identified date, and the allegation was that the resident reported to his/her family that PCA #107 refused to provide care. The notes indicated that PCA #107 stated resident #001 is total care and cannot do any care by him/herself and that he/she expected to assist with all ADLs.

Interview with PCA #106 revealed resident #001 is able to perform identified ADLs and wants to be independent. Interview with PCA #100 who is the full time PCA on the unit revealed he/she does everything for resident #001. Interview with RPN #101 revealed resident #001 is alert and fully able to discuss his/her needs.

Further interview with resident #001 revealed he/she has never told a PCA that he/she wants to be more independent and is able to perform an identified ADL. The resident stated he/she would never say that because he/she cannot perform the identified ADL.

The DOC confirmed that the home found no evidence of abuse during their investigation but acknowledged resident #001..s right to be treated with courtesy and respect and in a way that fully recognizes his/her individuality and respects his/her dignity was not fully respected and promoted. [s. 3. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #001's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity was fully respected and promoted, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee had failed to ensure that all doors that residents do not have access to must be kept closed and locked.

During the initial tour of the home on October 16, 2017, the inspector found the following doors to be unlocked and accessible to residents, staff and visitors:
• On an identified unit the shower room door had a piece of paper towel in the locking mechanism that enabled the door to be opened without a key. Interviews with PCA #113 and RPN #114 confirmed this door should be kept locked to prevent residents from entering the shower room where there are many lifts and shower chairs that would pose a fall hazard to residents.
• On an identified unit there was a room before the entrance to the unit (called a laundry room) that had forms and overflow documents from thinned out resident charts. RPN #112 confirmed this door should be kept locked as there is Personal Health Information in the charts.
• On an identified unit the laundry chute door was able to be opened. The door had a gray number locking mechanism. PCA #115 showed the inspector that the code could be entered on the locking mechanism which would render it locked. The inspector left the door locked.
• On an identified unit there was a room before the entrance of the unit (called a laundry room) that had resident charts. RPN #116 confirmed this door should be kept locked as there is Personal Health Information in the charts.
• On an identified unit the servery door was unlocked and there was no staff in attendance. The inspector noted chemicals, hot plates and a coffee machine that could pose a risk to residents. Interview with PCA #100 confirmed the door should be locked.

The faulty locking chute mechanism on the laundry chute door was brought to the Administrator's immediate attention. Interview with the Building Services Manager on October 17, 2017, revealed this lock was fixed the evening before.

Throughout the inspection the above mentioned doors were checked by inspectors #501 and #645 and were all found to be locked. [s. 9. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors that residents do not have access to are kept closed and locked, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

Resident #001 triggered for dignity lacking from stage one of the inspection from a resident interview by indicating that staff do not always help him/her as needed with an identified ADL. Resident #001 stated he/she was upset about the incident because he/she cannot perform an identified ADL and told RN #106 about the incident.

Interview with the DOC revealed he/she remembered investigating the above mentioned incident. Review of the home's investigation notes revealed that the incident occurred on an identified date, and the allegation was that the resident reported to his/her family that PCA #107 refused assist with the identified ADL. The notes indicated that PCA #107 stated resident #001 is total care and cannot do any care by him/herself.

Further interview with the DOC revealed the home did not report the above incident and investigation to the MOHLTC because he/she wanted to see if there was any concrete evidence to substantiate the allegation. The DOC admitted that in hindsight he/she should have reported the incident immediately and followed up with the results of the investigation when it was completed. The DOC confirmed that the home did not find any evidence that abuse had taken place but acknowledged that the home had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm had occurred and the home had not immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

Issued on this 21st day of November, 2017

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.