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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 12, 2018	2018_493652_0003	028661-17, 029248-17	Complaint

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

NATALIE MOLIN (652)

Inspection Summary/Résumé de l'inspection

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

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 30, 31, and February 1, 2, 6, 7, 2018

The following complaint intake were inspected log #028661-179 (related to unexpected death), 029248-17 (related to plan of care)

During the course of the inspection, the inspector(s) spoke with The Director of Care, Nurse Manager, Coroner, Medical Director, Resident Assessment Instrument - Minimum Data Set (RAI-MDS) Lead, Registered Nurses (RNs), Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs)

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee has failed to ensure that residents were protected from neglect by the licensee or staff in the home.

The purposes of the Act and this Regulation, "neglect" means

The failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A complaint was received by the Ministry of Health and Long Term Care (MOHLTC) regarding concerns related to the unexpected death of resident #001.

A Critical Incident System Report (CIS) submitted to the Ministry of Health and Long Term Care (MOHLTC), revealed the unexpected death of resident#001. On an identified date and time resident #001 was in bed and complained of pain in an identified body part. Registered staff assessed resident #001 and swelling was noted on an identified body part, vitals done. The medical doctor was in the building at the time and assessed resident #001 and ordered to send the resident to the hospital to rule out injury. Resident #001 was transferred to hospital and on an identified date, the hospital called the home to report resident #001 diagnosis. On an identified date and time, the hospital called the home to report resident #001 had passed away in hospital as a result of an identified diagnosis.

Record review of the Medical Doctor's communication binder for an identified unit on an identified dated, revealed a note that mentioned resident #001 complained of pain all over more than usual.

Record review of resident #001's healthcare records on an identified date, revealed resident #001 complained of pain all over and was administered an identified medication at an identified time. An identified medication was administered at an identified time. This progress note also revealed at an identified time resident #001 was still complaining of pain and a note was left for the doctor.

Record review of resident #001's physician orders on an identified date, revealed an order to increase the resident's identified medication to four times a day (QID).

Record review of resident #001's identified health care records for an identified period, revealed the resident had an identified medication order twice daily for an identified symptom which was administered twice daily from an identified period. This record also revealed this order was discontinued and there was a change in direction on an identified

date. The new order was to increase the identified medication four times a day (QID). Resident was administered the identified medication as per the new physician's orders on the following four consecutive days.
-1600H, 2000H
-0800H, 1200H, 1600H, 2000H
-0800H, 1200H, 1600H, 2000H
-0800H, 1200H

Record review of the Falls Prevention Lead's documentation of the resident incident records for six months prior to the resident's death, revealed there was no evidence to support resident #001 was included on the falls list and had not sustained a fall during this period.

Record review of resident #001's identified assessment for an identified period, revealed there was no evidence to support resident #001 sustained a fall.

Record review of resident #001's healthcare records on an identified date and time revealed the Registered Practical Nurse (RPN) called the hospital emergency to get an update on the resident's status and was informed the resident had an identified test done on an identified body part, pending results. This note also revealed the RPN called the hospital and was informed resident #001 was diagnosed with an identified diagnosis and was admitted to the hospital.

Record review of resident #001's healthcare records on an identified date and time, revealed the Registered Practical Nurse received a call from the Registered Nurse at an identified hospital and at an identified time informing the RPN that the resident had passed away in hospital.

Interview with the coroner revealed they were informed of resident #001's case by the hospital and resident #001's case was a coroner's case due to injury before death. They mentioned resident #001 did have an identified diagnosis and the medical cause of death was complications of an identified diagnosis. They also revealed resident #001's secondary diagnosis was related to underlying identified medical issues. The coroner called the director of care and was advised that there were no documented evidence resident #001 sustained a fall.

Interview with Personal Support Worker (PSW) #100 revealed resident #001 complained of unusual pain on an identified date, when they were providing care to the resident at an

identified time PSW #100 mentioned when they touched resident #001 to help identify the location of the pain, resident #001 said they were in pain. PSW #100 reported this to registered staff #101 that resident #001 verbalized pain and this was unusual for resident #001 to verbalize pain. PSW #100 also mentioned that RPN #101 checked resident #001 around an identified time.

Interview with RPN #101 revealed, that on an identified date, during an identified time, they were informed by PSW #100 that resident #001 complained of pain and it was unusual for resident #001 to call out for pain. RPN #101 mentioned they administered and identified medication to resident #001 and when they went back resident #001 said they were feeling a little better and left a note in the physician's communication binder regarding resident #001's complaint of pain. RPN #101 mentioned they returned to work two days later.

Interview with PSW #102 revealed when they were providing care for resident #001 around an identified date and time when they complained of pain all over which was unusual since resident #001 never complained of pain like that in the past. PSW #102 went on to say they reported to RPN #103 that resident #001 was in unusual pain. RPN #103 informed PSW #102 that another PSW had already reported it and resident #001 was on an identified medication for an identified diagnosis.

Interview with Registered Practical Nurse (RPN) #103 revealed when they worked on an identified date and on an identified shift, when they were informed by PSW #102 that resident #001 complained of pain. RPN #103 mentioned that they had administered an identified medication to resident #001 for the pain. RPN #103 also mentioned when they spoke to resident #001 regarding the complaint of pain, resident #001 mentioned that they had pain in an identified body part. RPN #103 mentioned they checked resident #001's identified body part and noticed nothing. RPN #103 mentioned that this information regarding resident #001's identified pain was not documented or communicated to the team. RPN #103 mentioned that they should have assessed resident #001's pain and done more to see if it was a new or old complaint. RPN #103 also revealed they did not advise the Registered Nurse In Charge of resident #001's complaint of pain for further assessment.

Interview with PSW #102 revealed they worked on an identified shift and reported to the RPN #101 around an identified time that resident #001 complained of unusual pain while being changed and RPN #101 advised PSW #102 that resident #001's pain had already been reported and the doctor prescribed an identified medication. PSW #102 mentioned

on the morning of an identified date at an identified time when they were providing care for resident # 001 they said I am really in pain, this was reported to RPN #101 who advised that the in-coming shift nurse will send resident #001 to the hospital.

Interview with RPN #101 revealed on an identified date, they inquired of PSW #102 to see how resident #001 was doing during the night, since resident #001 had already been receiving pain medication. On an identified date, PSW #102 informed RPN #101 that resident #001 was complaining of pain during care and to go and provide the care together since resident #001 was still complaining of pain. RPN #101 revealed when they went to assist PSW #102 with changing resident #001 the resident's identified body part had symptoms of injury and endorsed this information to the shift nurse on an identified date, to follow-up. During this interview RPN #101 revealed that they did not assess resident #001 further for pain, check resident #001's vital signs or inform the Registered Nurse In Charge on the shift to further assess resident #001.

Interview with the RN Nurse Manager revealed the expectation is that when resident #001 complained of unusual pain on an identified date, during the shift, RPN #103 and RPN #101 should have conducted a pain assessment, performed vital signs and a head to toe assessment on resident #001 and seek the assistance of the RN in-charge. The Nurse Manager also mentioned they worked on an identified date and did not receive a report that resident #001 was experiencing unusual pain.

Interview with the Director of Care revealed the expectation is that when resident #001 complained of pain in an identified body part and unusual pain on identified dates, during the shift, if the PSW is the first person aware, they should report to the registered staff who will assess the resident’s identified body part do the vital signs, check to see if it was minor or severe and depending on the severity call the doctor to determine if the resident needs to be sent out.

Record review and registered staff interviews revealed no evidence to support a thorough pain assessment, head to toe assessment or vitals signs had been performed when resident #001 complained of unusual pain on three identified dates. It has also been revealed that resident #001 complained of pain in an identified body part on an identified date, which had not been documented or communicated.

The lack of assessments and failure to communicate demonstrated a failure to provide the resident with the care required for health or well being and included an inaction that jeopardized the well being of the resident. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 29th day of March, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NATALIE MOLIN (652)
Inspection No. / No de l'inspection :	2018_493652_0003
Log No. / No de registre :	028661-17, 029248-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 12, 2018
Licensee / Titulaire de permis :	City of Toronto 55 John Street, Metro Hall, 11th Floor, TORONTO, ON, M5V-3C6
LTC Home / Foyer de SLD :	True Davidson Acres 200 Dawes Road, TORONTO, ON, M4C-5M8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Hao Chau

To City of Toronto, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The Licensee must be compliant with s. 19 of the LTCHA.
Specifically the licensee must:

Provide training to the registered practical nurses on the identified home areas and shift:
a) On the importance of collaborating with the Registered Nurse in charge if they are unable to complete a thorough assessment of a resident who has identified symptoms of pain that is unusual from any previous complaints of pain
b) On the importance of completing a thorough assessment of any resident who has identified symptoms of pain that is unusual from any previous complaints of pain, (i.e. pain assessment, head to toe assessment and vital signs where applicable).
c) On the importance of documenting and communicating to the relevant interdisciplinary team members when a resident has identified symptoms of pain that is unusual from any previous complaint of pain.
d) The home to keep a documented record of this training.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from neglect by the licensee or staff in the home.

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The lack of assessments and failure to communicate demonstrated a failure to provide the resident with the care required for health or well being and included an inaction that jeopardized the well being of the resident. [s. 19. (1)]

The severity of this noncompliance is actual harm. The scope is isolated. A review of the home's compliance history revealed previous unrelated noncompliance. As a result, a compliance order is warranted. (652)
(652)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 13, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 12th day of March, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector /
Nom de l'inspecteur : Natalie Molin

Service Area Office /
Bureau régional de services : Toronto Service Area Office