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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 18, 2019	2019_767643_0013	009850-17, 014294-17, 019951-17, 028597-17, 000927-18, 014390-18, 018478-18, 025979-18, 030435-18, 031508-18, 003222-19	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
365 Bloor Street East 15th Floor TORONTO ON M4W 3L4

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

ADAM DICKEY (643), PRAVEENA SITTAMPALAM (699)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 28, 29, April 1-5, and 8-10, 2019.

The following Critical Incident System (CIS) intakes were inspected during this inspection:
Log #009850-17; CIS #M586-000005-17 and Log #030435-18; CIS #M586-000037-18 - related to improper transferring and positioning techniques;
Log #014294-17; CIS #M586-000013-17 and Log #018478-18; CIS #M596-000027-18 - related to suspected abuse;
Log #014390-18; CIS M586-000021-18 - related to injury with unknown cause;
Log #003222-19; M586-000010-19 - related to responsive behaviours;
Log #019951-17; CIS #M586-000019 - related to alleged abuse; and
Log #028597-17; CIS M586-000030-17, Log #000927-18; CIS #M586-000003-18, Log#025979-18; CIS M586-000033-18 and Log#031508-18; CIS M586-000041-18 - related to falls prevention and management.

A Written Notification related to O. Reg. 79/10, s. 231. (a) identified in concurrent inspection 2019_767643_0012 (Log #015849-17) will be issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), clinical and operational Nurse Managers (NM), acting Nurse Managers, Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Physiotherapist (PT), Registered Occupational Therapist (OT), Personal Support Workers (PSW), rehabilitation assistant, residents and family members.

During the course of the inspection, the inspector(s) conducted observation of staff and resident interactions and the provision of care, reviewed resident health records, staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

7 WN(s)
1 VPC(s)
3 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	Légende 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. 2007, c. 8, s. 6 (7).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and consistent and complemented each other.

The Ministry of Health and Long-Term Care (MOHLTC) received two CIS reports related to incidents that resulted in significant changes in a resident's health status. Review of the CIS reports showed that on two identified dates three months apart resident #033 was found on the floor, and was sent to hospital where they were diagnosed with identified injuries.

Record review of resident #033's progress notes indicated that from an identified five month period, the resident had 14 documented falls.

Review of resident #033's progress notes showed that on an identified date in the second month of the above mentioned five month period, OT #111 identified a potential trigger for the resident's falls. OT #111 recommended two specified fall prevention and management interventions. Further review of progress notes by the OT, showed on on an identified date in the last month of the five month period, the OT saw resident #033 and documented that they had the same recommendations as mentioned previously. There was no documentation to indicate that OT #111 had discussed their recommendations with nursing staff.

Review of resident #033's progress notes showed that on an identified date in the first month of the above mentioned five month period, PT #112 identified that most falls occurred at two specified periods of the day. PT #112 recommended three specified fall prevention and management interventions. Further review of progress notes by PT #112 showed they provided recommendations for interventions in the second, third and last month of the five month period.
The progress notes did not indicate that PT #112 had discussed their recommendations with nursing staff.

Record review of the care plans from the above mentioned five month period showed no indication that the recommended interventions were included in resident #033's care plans. Inspector #699 conducted observations during the inspection, and the above mentioned interventions were not observed.

In separate interviews with OT #111 and PT #112, they stated that they would receive referrals to assess a resident upon admission to the home, quarterly and when a resident has had a fall or a change in health status. Both OT #111 and PT #112 stated that they would document their recommendations in the progress notes and sometimes verbally tell the nurses if there were any recommendations or equipment needed. OT #111 stated that it was the responsibility of the nurses to follow-up on the referral and update the care plan. They further stated if that they cannot verbally tell the nurses about the recommendations, they would follow-up the following week to see if the recommendations were working. OT #111 acknowledged that there was a lack of documentation on the follow up of the recommendations.

In an interview with RPN #140, they stated that occasionally the recommendations of the PT and OT are not communicated to the nursing staff. They further stated that the nurses do not have time to go through the progress notes to see if there is a note from either the

OT or PT. RPN #140 acknowledged there was no collaboration between staff to initiate the recommended fall interventions for resident #033.

In an interview with NM #141, they stated their expectation would be for staff to discuss and collaborate with each other regarding falls preventions and management recommendations. NM #141 acknowledged there was a lack of communication between the team related to resident #033.

In an interview with DOC #123, they acknowledged that there was no collaboration between the staff to reassess and initiate falls prevention and management interventions for resident #033. [s. 6. (4) (b)]

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

A CIS report was submitted by the home related to an incident in which resident #020 was taken to hospital and which resulted in a significant change in the resident's health status. According to the CIS report on an identified date, resident #020 was being assisted to stand by a PSW while providing care when they lost balance and fell. Resident #020 was admitted to hospital seven days later, and diagnosed with a specified injury.

Review of resident #020's progress notes showed that on the above identified date, during specified care, they were assisted by a PSW to stand. The progress note indicated that resident #020 suddenly pushed the PSW back, lost balance and fell, sustaining an injury. Range of motion was assessed as normal following the incident. Progress notes further showed that signs of additional injury were observed three days later, and was assessed by the Physician five days following the fall, and sent to hospital for x-ray. Review of the home's internal incident report completed by RPN #135 showed that during specified care on the above mentioned date, resident #020 was assisted by a PSW to stand when they had a fall. The incident report showed the incident was observed by PSW #134.

Review of resident #020's plan of care last updated two months prior to the incident, showed that the resident required extensive to total assistance with weight bearing help from two staff for transferring. The plan of care further showed that resident #020 required two-person total assistance for dressing. Resident #020 also required two-person total assistance from staff for toileting and personal hygiene.

In an interview, RPN #135 indicated that on the identified date, resident #020 had a fall on their shift while PSW #134 was providing care. RPN #135 indicated that PSW #134 was by alone when assisting resident #020 to stand when they pushed back against PSW #134 and fell. RPN #135 indicated that no other staff members were assisting with care when the fall occurred and that PSW #134 could normally handle resident #020's care alone.

In an interview, PSW #134 indicated they were assisting resident #020 with care when the fall incident occurred. PSW #134's account of the incident did not corroborate with RPN #135 account nor with the progress notes and incident report, and indicated resident #020 stood up on their own when the fall occurred.

In an interview, the DOC indicated that resident #020 required two-person assistance for transferring, dressing, toileting and standing. The DOC acknowledged that PSW #134 had not followed resident #020's plan of care by assisting them to stand without the assistance of another staff member. The DOC acknowledged that the care set out in resident #020's plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

3. The licensee has failed to ensure that when a resident was reassessed and the plan of care was reviewed and revised because care set out in the plan had not been effective, different approaches had been considered in the revision of the plan of care.

The MOHLTC received two CIS reports, related to incidents that resulted in a significant changes in resident #033's health status.

Record review of resident #033's progress notes indicated they fell 14 times over an identified five month period.

Record review of resident #033's updated in the first month of the five month period showed interventions were in place for falls prevention and management. Review of the care plan for the remaining four months showed interventions were updated three times, with only one new intervention entered into the plan of care.

In an interview with RN #140, they stated resident #033 had declined in mobility and was at risk for falls. RN #140 acknowledged that resident #033's care plan was not effective to prevent falls and minimize injury.

In an interview with NM #141, they stated that for resident #033, they would have expected the care plan be reassessed if the resident continued to fall. NM #141 acknowledged that the fall prevention and management interventions for resident #033 were not effective.

In an interview with DOC #123, they stated that staff would know if fall interventions were effective if there was a decrease in the number of falls. DOC #123 acknowledged that resident #033's fall interventions should have been reassessed and different approaches considered when the resident continued to fall. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 001, 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place was complied with.

As required by the Regulation (O. Reg. 79/10, s. 48 (1). 1) the licensee was required to ensure that an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury was implemented in the home. As required by the

Regulation (O. Reg. 79/10, s. 30 (1). 1) a written description of the program was required that included its goals and objectives and relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Review of the home's policy titled Falls Prevention and Management, RC-0518-21, published October 01, 2016, indicated as part of post fall management, head injury routine monitoring (HIR) will be initiated every hour for 24 hours or as ordered by physician.

The Ministry of Health and Long-Term Care (MOHLTC) received two CIS reports related to incidents that resulted in significant changes in resident #033's health status.

Record review of resident #033's progress notes indicated that from an identified five month period, the resident had 14 documented falls.

Record review of resident #033's HIR documentation, indicated on specified days, HIR was not completed hourly for identified periods of time following two documented un-witnessed falls:

In an interview with RPN #140, they stated HIR is initiated if a resident had an un-witnessed fall and/or if resident has an injury to their head. RPN #140 stated that for HIR, they would complete it every 15 minutes four times, every half an hour for four times and then every hour for four times. They further stated they were not aware that the policy indicated that HIR be completed every hour for 24 hours. RPN #140 acknowledged that HIR was not completed as per policy.

In an interview with DOC #123, they acknowledged that for resident #033, HIR was not completed as per policy. [s. 8. (1) (a),s. 8. (1) (b)]

2. In accordance with O.Reg 79/10, s. 53(1)(1), the licensee was required to ensure that written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other were developed to meet the needs of residents with responsive behaviour.

Record review of the home's policy titled "Altercations and Potentially Harmful Interactions between and among residents", RC-0306-00, indicated that after an alleged,

suspected and/or observed altercation between or among residents, the following is to be done:
-Conduct a physical, intellectual, emotional, capability, environmental and social (PIECES) assessment;
-Notify the physician as indicated by the results of the assessment and, in consultation with physician, arrange for further assessment such as through the behavioural support nurse or geriatric mental health outreach team;
-Continuously monitor resident and report any unusual behaviour/reaction to assault using the modified dementia observation system (DOS) monitoring tool.

a. The MOHLTC received a CIS report on an identified date, related to an incident that caused injury which resulted in significant change to resident #031. Review of the CIS indicated that resident #031 had an altercation with resident #032, which caused resident #031 to fall. Resident #031 was found on the floor and reported to staff what had occurred. Resident was sent to hospital and was diagnosed with a specified injury which required treatment in hospital.

Record review of resident #032's progress notes indicated that on four occasions prior to the above incident, the resident had demonstrated identified responsive behaviours towards co-residents. Review of resident #032's health records did not indicate that a behavior assessment tool, such as PIECES assessment or DOS monitoring tool, was initiated after above mentioned resident to resident incidents.

In an interview with RN #129, they stated if a resident was exhibiting responsive behaviours, they would follow the policy and procedures related to aggressive behaviours, such as updating care plan, initiate DOS, document in progress notes and inform nurse manager.

In an interview with NM #122, they stated if there is an altercation between residents the expectation is for staff to complete an incident report, initiate a monitoring document and notify nurse manager or DOC.

In an interview with DOC #123, they stated for residents who were exhibiting responsive behaviours, they would expect DOS to be initiated. The DOC further stated they would have expected DOS to be initiated for resident #032 after the above mentioned incidents.

b. The MOHLTC received two CIS reports, related to incidents that resulted in significant changes in resident #033's health status.

Record review of resident #033's progress notes showed an additional fall incident occurred on an identified date, when resident #033 was involved in an altercation with resident #035. Resident #033 was assessed and noted to have a specified injury.

In an interview with PSW #128, they stated they witnessed the above altercation. They further stated that resident #035 was redirected away from resident #033 and there were no other concerns of altercations between those two residents.

Review of resident #035's clinical health chart and progress did not indicate that a behavior assessment tool, such as PIECES assessment or DOS monitoring tool, was initiated after above mentioned resident to resident incident.

In an interview with RN #129, they stated if a resident was exhibiting responsive behaviours, they would follow the policy and procedures related to aggressive behaviours, such as updating care plan, initiate DOS, document in progress notes and inform nurse manager.

In an interview with NM #122, they stated if there is an incident where a resident is hit by another resident, the expectation is for staff to complete an incident report, initiate a monitoring document and notify nurse manager or DOC.

In an interview with DOC #123, they stated for residents who were exhibiting responsive behaviours, they would expect DOS to be initiated. The DOC further stated they would have expected DOS to be initiated for resident #035 after the above mentioned incident. [s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: 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 :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

Physical abuse as outlined in section 2. (1) of the Regulation (O.Reg.79/10) means the use of physical force by a resident that causes physical injury to another resident.

The MOHLTC received a CIS report on an identified date, related to an incident that caused injury which resulted in significant change to resident #031. Review of the CIS indicated that resident #031 had an altercation with resident #032, which caused resident #031 to fall. Resident #031 was found on the floor and reported to staff what had occurred. Resident was sent to hospital and was diagnosed with a specified injury which required treatment in hospital.

Record review of resident #031's health records showed that the resident was admitted to the home with identified diagnoses. Record review of resident #031's MDS assessments showed that they required additional staff assistance for identified care tasks following the above incident.

Record review of resident's #032's clinical health record showed that the resident was admitted to the home with identified diagnoses. Record review of resident #032's admission MDS assessment showed that the resident was cognitively impaired and exhibited identified responsive behaviours almost daily which were not easily altered.

Record review of resident #032's progress notes indicated that on four occasions prior to the above incident, the resident had demonstrated identified responsive behaviours towards co-residents.

Review of resident #031's progress notes showed that four days prior to the above incident, a referral to social work was completed as resident #031 had concerns about the behaviour of resident #032. Review of resident #032's progress notes showed that on the above identified date, resident #032 was observed exhibiting identified responsive behaviours. Resident #031 was found on floor and stated that resident #032 had exhibited specified responsive behaviour toward them.

Record review of resident #032's care plan prior to the above mentioned identified date, showed no behavioural triggers or interventions related to resident #032's identified responsive behaviours were identified.

In an interview with PSW #128, they stated that they were aware of resident #032's identified responsive behaviours. PSW #128 reported that resident #032 occasionally exhibited responsive behaviours toward co-residents. They further stated they had to monitor the resident hourly and be aware of the resident's whereabouts.

In an interview with RN #129, they stated that resident #032 demonstrated identified responsive behaviours upon admission to the home. RN #129 stated that resident #032 exhibited identified responsive behaviours toward co-residents. RN #129 acknowledged that resident #032's care plan should have been updated with interventions related to their behaviours. They further acknowledged that resident #031 was not protected from harm in this situation.

In an interview with NM #127, they stated that the expectation of the home was that if a resident was exhibiting responsive behaviours, including physical aggression, was to review the care plan and update if there is new behaviour. They further stated if the interventions were not working to decrease the behaviour, new interventions should be tried. NM #127 acknowledged for resident #031, they were not kept safe from abuse by resident #032.

The severity of this finding was a level 3, indicating actual harm. The scope was a level 1, indicating the issue was related to one of three residents reviewed. A review of the home's compliance history was a level 3 , indicating one or more related non-compliance in the last 36 months. According to the judgement matrix, a compliance order (CO) is warranted, however, it has been confirmed through the inspection and the home's compliance history since the time of these incidents, that non-compliance related to LTCHA 2007, c. 8, s. 19 (1) has been addressed and rectified by the home. A written notification (WN) is being issued. [s. 19. (1)]

WN #4: 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 :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred or may occur immediately reported the suspicion and the information upon which it is based to the Director.

The MOHLTC received two CIS reports, related to incidents that resulted in significant changes in resident #033's health status.

Record review of resident #033's progress notes showed an additional fall incident occurred on an identified date, when resident #033 was involved in an altercation with resident #035. Resident #033 was assessed and noted to have a specified injury.

In an interview with PSW #128, they stated they witnessed the above altercation. They further stated that resident #035 was redirected away from resident #033 and there were no other concerns of altercations between those two residents.

Review of the home's incident report for the above identified date, showed the report was endorsed by both the DOC and Administrator.

In an interview with DOC #123, they stated that a CIS report should have been submitted to the MOHLTC regarding the above incident. [s. 24. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of

altercations and potentially harmful interactions between residents by identifying and implementing interventions.

The MOHLTC received a CIS report on an identified date, related to an incident that caused injury which resulted in significant change to resident #031. Review of the CIS indicated that resident #031 had an altercation with resident #032, which caused resident #031 to fall. Resident #031 was found on the floor and reported to staff what had occurred. Resident was sent to hospital and was diagnosed with a specified injury which required treatment in hospital.

Record review of resident #033's progress notes showed an additional fall incident occurred on an identified date, when resident #033 was involved in an altercation with resident #035. Resident #033 was assessed and noted to have a specified injury.

Record review of resident's #032's clinical health record showed that the resident was admitted to the home with identified diagnoses. Record review of resident #032's admission MDS assessment showed that the resident was cognitively impaired and exhibited identified responsive behaviours almost daily which were not easily altered.

Record review of resident #032's progress notes indicated that on four occasions prior to the above incident, the resident had demonstrated identified responsive behaviours towards co-residents.

Record review of resident #032's care plan prior to the above identified date, showed no behavioural triggers or interventions related to resident #032's responsive behaviours toward co-residents.

In an interview with PSW #128, they stated that they were aware of resident #032's identified responsive behaviours. PSW #128 reported that resident #032 occasionally exhibited responsive behaviours toward co-residents. They further stated they had to monitor the resident hourly and be aware of the resident's whereabouts.

In an interview with RN #129, they stated that resident #032 demonstrated identified responsive behaviours upon admission to the home. RN #129 stated that resident #032 exhibited identified responsive behaviours toward co-residents. RN #129 acknowledged that resident #032's care plan should have been updated with interventions related to their behaviours.

Record review of the home's policy titled "Altercations and Potentially Harmful Interactions Between and Among Residents", RC-0306-00, indicated that after an alleged, suspected and/or observed altercation between or among residents, the following is to be done:
-Identify factors that could potentially trigger altercations; and
-Identify interventions to minimize risk and incorporate into care plan.

In an interview with NM #127, they stated that the expectation of the home was when resident exhibited responsive behaviours, including physical aggression, the care plan should be reviewed and updated when there is new behaviour. They further stated for resident #032 interventions were not effective to decrease the behaviour and new interventions should have been tried. NM #127 acknowledged for resident #032, the expectation would have been to update the care plan after the first resident to resident altercation was noted and involve the NM. They acknowledged that there were gaps in identifying and implementing interventions to prevent the risk of resident to resident altercations for resident #032.

The severity of this finding was a level 3 indicating actual harm to the resident. The scope was a level 1, indicating the issue was related to one of three residents reviewed. A review of the home's compliance history was a level 2, indicating one or more unrelated non-compliance in the last 36 months. According to the judgement matrix, a compliance order (CO) is warranted, however, it has been confirmed through the inspection and the home's compliance history since the time of these incidents, that non-compliance related to O. Reg. 79/10, s. 54. has been addressed and rectified by the home. A written notification (WN) is being issued. [s. 54. (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff received annual training in all the areas required under subsection 76. (7) of the Act.

The MOHLTC received a CIS report related to an alleged staff to resident abuse. Review of the CIS indicated that on an identified date, PSW #120 was assisting RN#129 and PSW #121 in providing care to resident #032. Resident #032 demonstrated identified responsive behaviours toward PSW #120 during care. PSW #120 allegedly pushed the resident which was witnessed by two other staff members.

Review of the home's investigation notes revealed that interviews were conducted with PSW #120, PSW #121 and RN #129. PSW #120 received discipline as result of the investigation. Resident #032 had no reported injury or harm from the incident.

Review of the home's training records showed that for the course titled "Behaviour Management" in two identified years, PSW #120's status was "registered/overdue" in both years. Further review of the training records showed that staff completion of Behaviour Management course was 74 per cent and 80 per cent in the above identified years.

In an interview with DOC #123, they stated that the "Behaviour Management" course was provided to give staff training on responsive behavior and was a mandatory course to be completed by all staff annually. They further indicated "registered/overdue" status indicated that the course was not completed. The DOC indicated it was the responsibility of nurse managers to ensure that staff have completed the courses. DOC #123 acknowledged that for PSW #120, the course was not completed as required. [s. 221. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was created and maintained for each resident of the home.

a. The MOHLTC received a CIS report related to an incident that caused injury which resulted in significant change to resident #031's health status.

Inspector #699 requested the home provide progress notes for resident #031 for a specified two-month time period. Through record review, Inspector #699 noted that progress notes from an identified two week period were not provided. Inspector #699 made a request to DOC for the provision of those documents again at that time.

In an interview with DOC #123, they stated they could not locate the progress notes for that specified time period that was requested. DOC acknowledged resident #031's written record was not maintained.

b. The following evidence related to resident #002 was found under inspection report 2019_767643_0012.

The MOHLTC received anonymous complaints through the Actionline. According to the complaints, a staff member of the home was believed to be acting against the home's policies and also had failed to report that resident #002 fell while in their care.

Record review of resident #002's progress notes showed that on an identified date, RPN #103 documented that resident #002 was found on the floor. The note further indicated that the assigned PSW #115 had left the resident unattended. Further review of the progress notes indicated the resident experienced falls on two additional identified dates.

In interviews, RPNs #103, #116 and #117 indicated that when a resident has fallen it was the process in the home for registered staff to complete a fall incident report and a post fall assessment huddle form to assess the resident and to analyze the fall incident. RPN #103 further indicated that for one of the above identified fall incidents, they had completed the fall incident report and the post fall assessment huddle forms.

In an interview, DOC#123 indicated that when the staff complete the falls incident report and post fall huddle for a resident's fall these documents are reviewed for the previous month at the monthly falls committee meetings.

Record review of the home's monthly Falls Committee Meeting Minutes revealed the above identified falls for resident #002 were discussed. Review of resident #002's health records could not locate the record of the falls incident reports and post fall assessment huddle forms for fall incidents for the above mentioned fall incidents.

In an interview DOC #123 indicated that in 2018 the home's process for filing incident reports had changed and upon the DOC's review of resident #002's archived records, the DOC #123 acknowledged they did not locate the fall incident reports and the post fall huddles for resident #002's falls. [s. 231. (a)]

Issued on this 23rd day of April, 2019

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

Ministère 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) :	ADAM DICKEY (643), PRAVEENA SITTAMPALAM (699
Inspection No. / No de l'inspection :	2019_767643_0013
Log No. / No de registre :	009850-17, 014294-17, 019951-17, 028597-17, 000927-18, 014390-18, 018478-18, 025979-18, 030435-18, 031508-18, 003222-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 18, 2019
Licensee / Titulaire de permis :	City of Toronto 365 Bloor Street East, 15th Floor, TORONTO, ON, M4W-3L4
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

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

Ministère 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

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

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

Ministère 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

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. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The licensee must be compliant with LTCHA 2007, c. 8, s. 6 (4).

Specifically, the licensee must:
1) Ensure that for resident #033 and all other residents that strategies and recommendations from the interdisciplinary team are communicated to the direct care staff, are included in the resident's written plan of care and implemented;
2) Develop an on-going auditing process to ensure referrals addressed by the interdisciplinary team are followed up on by direct care staff to ensure recommendations are considered and implemented as appropriate in the plan of care; and
3) Maintain a written record of audits conducted in the home. The written record must include the date of the audit, the resident's name, the name of the person completing the audit and the outcome of the audit.

Grounds / Motifs :

1. The licensee has failed to ensure that when a resident was reassessed and the plan of care was reviewed and revised because care set out in the plan had not been effective, different approaches had been considered in the revision of the plan of care.

The MOHLTC received two CIS reports, related to incidents that resulted in a significant changes in resident #033's health status.

Record review of resident #033's progress notes indicated they fell 14 times over an identified five month period.

Record review of resident #033's updated in the first month of the five month period showed interventions were in place for falls prevention and management. Review of the care plan for the remaining four months showed interventions were updated three times, with only one new intervention entered into the plan of care.

In an interview with RN #140, they stated resident #033 had declined in mobility and was at risk for falls. RN #140 acknowledged that resident #033's care plan was not effective to prevent falls and minimize injury.

In an interview with NM #141, they stated that for resident #033, they would have expected the care plan be reassessed if the resident continued to fall. NM #141 acknowledged that the fall prevention and management interventions for resident #033 were not effective.

In an interview with DOC #123, they stated that staff would know if fall interventions were effective if there was a decrease in the number of falls. DOC #123 acknowledged that resident #033's fall interventions should have been reassessed and different approaches considered when the resident continued to fall.

The severity of this issue was determined to be a level 3 as there was actual harm to resident #033. The scope of the issue was a level 1 as it related to one out of three residents reviewed. The home had a level 2 history as there were 1 or more unrelated non-compliances issued in the last 36 months.
(643)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2019

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

Ministère 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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with LTCHA 2007, c. 8, s. 6 (7).

Specifically the licensee must:
1) Ensure that for resident #020 and all other residents with similar care needs, that care is provided with two staff members as specified in the plan of care;
2) Develop an auditing system in the home to ensure staff are assisting with two staff members as specified in the plan of care; and
3) Maintain a written record of audits conducted in the home. The written record must include the date and location of the audit, the resident's name, staff members audited, the name of the person completing the audit and the outcome of the audit.

Grounds / Motifs :

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

A CIS report was submitted by the home related to an incident in which resident #020 was taken to hospital and which resulted in a significant change in the resident's health status. According to the CIS report on an identified date, resident #020 was being assisted to stand by a PSW while providing care when they lost balance and fell. Resident #020 was admitted to hospital seven days later, and diagnosed with a specified injury.

Review of resident #020's progress notes showed that on the above identified date, during specified care, they were assisted by a PSW to stand. The progress note indicated that resident #020 suddenly pushed the PSW back, lost balance and fell, sustaining an injury. Range of motion was assessed as normal following

the incident. Progress notes further showed that signs of additional injury were observed three days later, and was assessed by the Physician five days following the fall, and sent to hospital for x-ray. Review of the home's internal incident report completed by RPN #135 showed that during specified care on the above mentioned date, resident #020 was assisted by a PSW to stand when they had a fall. The incident report showed the incident was observed by PSW #134.

Review of resident #020's plan of care last updated two months prior to the incident, showed that the resident required extensive to total assistance with weight bearing help from two staff for transferring. The plan of care further showed that resident #020 required two-person total assistance for dressing. Resident #020 also required two-person total assistance from staff for toileting and personal hygiene.

In an interview, RPN #135 indicated that on the identified date, resident #020 had a fall on their shift while PSW #134 was providing care. RPN #135 indicated that PSW #134 was by alone when assisting resident #020 to stand when they pushed back against PSW #134 and fell. RPN #135 indicated that no other staff members were assisting with care when the fall occurred and that PSW #134 could normally handle resident #020's care alone.

In an interview, PSW #134 indicated they were assisting resident #020 with care when the fall incident occurred. PSW #134's account of the incident did not corroborate with RPN #135 account nor with the progress notes and incident report, and indicated resident #020 stood up on their own when the fall occurred.

In an interview, the DOC indicated that resident #020 required two-person assistance for transferring, dressing, toileting and standing. The DOC acknowledged that PSW #134 had not followed resident #020's plan of care by assisting them to stand without the assistance of another staff member. The DOC acknowledged that the care set out in resident #020's plan of care was not provided to the resident as specified in the plan.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it applied to one of

three residents. The home had a level 3 compliance history as there were 1 or more related non-compliances issued in the last 36 months that included: Voluntary Plan of Correction (VPC) issued November 18, 2016 (2016_382596_0014).
(643)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2019

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Order / Ordre :

The licensee must be compliant with LTCHA 2007, c. 8, s. 6 (11).

Specifically the licensee must:
1) Ensure that for resident #033 and all other residents, the written plan of care related to falls prevention and management is reviewed and revised with different approaches when the care set out in the plan is ineffective;
2) Develop an on-going auditing process to ensure that when resident #033 specifically, and any resident falls, that the effectiveness their current fall interventions are reviewed and documented and, if required, plan of care revised with new interventions using an interdisciplinary approach; and
3) Maintain a written record of audits conducted in the home. The written record must include the date of the audit, the resident's name, the name of the person completing the audit and the outcome of the audit.

Grounds / Motifs :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and consistent and complemented each other.

The Ministry of Health and Long-Term Care (MOHLTC) received two CIS reports related to incidents that resulted in significant changes in a resident's health

status. Review of the CIS reports showed that on two identified dates three months apart resident #033 was found on the floor, and was sent to hospital where they were diagnosed with identified injuries.

Record review of resident #033's progress notes indicated that from an identified five month period, the resident had 14 documented falls.

Review of resident #033's progress notes showed that on an identified date in the second month of the above mentioned five month period, OT #111 identified a potential trigger for the resident's falls. OT #111 recommended two specified fall prevention and management interventions. Further review of progress notes by the OT, showed on on an identified date in the last month of the five month period, the OT saw resident #033 and documented that they had the same recommendations as mentioned previously. There was no documentation to indicate that OT #111 had discussed their recommendations with nursing staff.

Review of resident #033's progress notes showed that on an identified date in the first month of the above mentioned five month period, PT #112 identified that most falls occurred at two specified periods of the day. PT #112 recommended three specified fall prevention and management interventions. Further review of progress notes by PT #112 showed they provided recommendations for interventions in the second, third and last month of the five month period. The progress notes did not indicate that PT #112 had discussed their recommendations with nursing staff.

Record review of the care plans from the above mentioned five month period showed no indication that the recommended interventions were included in resident #033's care plans. Inspector #699 conducted observations during the inspection, and the above mentioned interventions were not observed.

In separate interviews with OT #111 and PT #112, they stated that they would receive referrals to assess a resident upon admission to the home, quarterly and when a resident has had a fall or a change in health status. Both OT #111 and PT #112 stated that they would document their recommendations in the progress notes and sometimes verbally tell the nurses if there were any recommendations or equipment needed. OT #111 stated that it was the responsibility of the nurses to follow-up on the referral and update the care plan.

They further stated if that they cannot verbally tell the nurses about the recommendations, they would follow-up the following week to see if the recommendations were working. OT #111 acknowledged that there was a lack of documentation on the follow up of the recommendations.

In an interview with RPN #140, they stated that occasionally the recommendations of the PT and OT are not communicated to the nursing staff. They further stated that the nurses do not have time to go through the progress notes to see if there is a note from either the OT or PT. RPN #140 acknowledged there was no collaboration between staff to initiate the recommended fall interventions for resident #033.

In an interview with NM #141, they stated their expectation would be for staff to discuss and collaborate with each other regarding falls preventions and management recommendations. NM #141 acknowledged there was a lack of communication between the team related to resident #033.

In an interview with DOC #123, they acknowledged that there was no collaboration between the staff to reassess and initiate falls prevention and management interventions for resident #033.

The severity of this issue was determined to be a level 3 as there was actual harm to resident #033. The scope of the issue was a level 1 as it related to one out of three residents reviewed. The home had a level 2 history as there were 1 or more unrelated non-compliances issued in the last 36 months.
(699)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2019

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

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 18th day of April, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Adam Dickey

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