Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Original Public Report

Report Issue Date July 14, 2022
Inspection Number 2022_1590_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
City of Toronto

Long-Term Care Home and City
True Davidson Acres, Toronto

Lead Inspector
April Chan (704759)

Additional Inspector(s)
Wing-Yee Sun (708239)
Inspector #740849 (Fiona Wong) and Inspector #741673 (Rajwinder Sehgal) were also present during this inspection.

Inspector Digital Signature
April W Chan
Digitally signed by April W Chan
Date: 2022.07.20 10:21:05 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following dates: June 15 - 17, 20, 22 - 24, 27, and 28, 2022.

The following intakes were inspected in this complaint and critical incident inspection:

- Intake #014583-21 (CIS #M586-000018-21) related to alleged resident to resident abuse
- Intake #015324-21 (CIS #M586-000019-21) related to alleged resident to resident abuse
- Intake #004969-22 (CIS #M586-000008-22) related to alleged staff to resident abuse

- Intake #006461-22 (Complaint) related to reporting and complaints, multiple care concerns, and alleged abuse and neglect

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

- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Reporting and Complaints
- Resident Care and Support Services
- Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION GENERAL REQUIREMENTS FOR PROGRAMS

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 30 (2)

The licensee has failed to ensure that any actions taken with respect to a resident under the skin and wound care program, including assessments, reassessments and the resident's response to interventions are documented.

Rationale and Summary

The resident was at risk for impaired skin integrity and developed a skin alteration.

One wound assessment was completed on a specific date. Local skin and wound care were ordered for a specific period. The home's policy for skin and wound prevention and management stated that team members should implement a plan for skin and wound management, reassess and document progress weekly.

A registered Practical Nurse (RPN) and the Director of Care (DOC) indicated that the Weekly Wound Assessment tool should be done weekly by registered staff when the wound dressing was changed for the resident. The risk to the resident was minimal when the weekly wound assessment was not documented because registered staff would have assessed while dressing the wound.

Sources: the residents clinical records; home's policy on skin care and wound prevention and management, interviews with registered staff and DOC. [s. 50 (2) (b) (iv)] (704759)

WRITTEN NOTIFICATION PLAN OF CARE

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 6 (4) (a)

The licensee has failed to ensure that staff members and others involved in the different aspects of care of a resident collaborated with each other in their assessments so that their assessments were consistent and integrated.

Rationale and Summary

A complaint was received by the Ministry of Long-Term Care (MLTC) that the home neglected the care needs of the resident.

The resident had cognitive impairment and was at times able to describe their pain using a numerical scale.

On a specific date, the resident complained of pain. A pain medication was given and endorsed to staff at shift change in the resident's clinical notes.

Approximately five hours later, the resident was assessed and denied pain. Clinical assessments including the numerical pain tool, vitals check including blood pressure, pulse, and respirations was done approximately seven hour later. The home indicated that vital signs for the resident were within normal ranges. Registered staff and DOC indicated that assessments including vital signs should have been done when the resident experienced pain.

The home's policy on pain assessment directed registered staff to complete the pain assessment when a resident requests for pain medication. Registered staff and DOC indicated that the pain assessment should have been completed approximately thirty minutes after administration time.

The need for ongoing monitoring and assessment of pain for the resident was expected to be communicated to the oncoming shift. Furthermore, based on severity, the home would expect staff to notify the home's physician or nurse practitioner.

The concern was documented in progress notes, and not in the communication book between registered staff, nor in the communication book to the physician. The DOC also indicated that the expectation during shift change was for the incoming registered staff member to generate and review the 24-hour shift report. The resident was at low risk of harm when the home missed assessments for pain as clinical monitoring indicators were within normal limits.

Sources: The resident's clinical records, review of the home's policy on pain assessment and management, review of the doctor's communication book and shift report book, interviews with the complainant, registered staff, and DOC. [s. 6 (4) (a)] (704759)

WRITTEN NOTIFICATION PLAN OF CARE

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 6 (5)

The licensee has failed to ensure that a resident, and the resident's substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary

The resident complained of pain on a specific date and was given pain management by registered staff. The resident was reassessed and denied pain later that day.

Registered staff and DOC indicated that the home should have notified the power of attorney (POA) regarding the resident's pain. The resident's POA was not notified regarding the onset of pain. There was low risk to the resident when their POA was not notified when the resident had pain.

Sources: The resident's clinical records, interviews with the complainant, registered staff, and DOC. [s. 6 (5)] (704759)

WRITTEN NOTIFICATION PLAN OF CARE

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 6 (7)

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

Rationale and Summary

On a specific date, the resident was provided morning care earlier than normal. The resident identified that the time of interaction at night was unusual. A personal support worker (PSW) indicated that morning care and dressing was provided to resident at a different time. A nurse manager (NM) indicated that the job routine for the day shift, including morning care and dress, should not have been provided to the resident at a different time.

The resident's plan of care did not indicate preference to receive morning care and dress at a different time. Morning care and dressing to the resident on a specific date was not provided as specified in the plan of care.

Sources: the resident's care plan, interviews with the resident, nurse manager and other staff. [s. 6 (7)] (704759)

WRITTEN NOTIFICATION PREVENTION OF ABUSE AND NEGLECT

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 19 (1)

The licensee has failed to ensure that five residents were protected from sexual abuse by another resident.

In accordance with the definition identified in section 2 (1) of the Regulation 79/10 "sexual abuse" means any non-consensual touching, behaviour or remarks of a sexual nature or

sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Rationale and Summary

The resident was admitted with a history of exhibiting responsive behaviours. Resident was first referred to the home's Behavioural Supports Ontario (BSO) Lead on a specific date, when they exhibited behaviours towards co-residents. Initial interventions for inappropriate sexual behaviours were initiated a day later.

(i) On a specific date, the resident was observed touching a co-resident, and making inappropriate sexual comments to them. This resident appeared uncomfortable and fearful when touched.

A PSW witnessed this resident being touched by another resident. An RPN reported this resident appeared frightened when they were touched. Both staff members identified that this resident was not able to provide consent to the touching and confirmed resident to resident sexual abuse had occurred.

Sources: CIS report #M586-000018-21, the resident's progress notes, interviews with a PSW and other staff.

(ii) On a specific date, there were multiple incidents in which the resident demonstrated sexually responsive behaviors toward co-residents. Another resident reported to the home that the resident entered their room and inappropriately touched them. This resident who made the report, identified to staff that they felt violated by the resident and wanted police involvement.

During the same day, staff witnessed the resident inappropriately touching a second co-resident and the two residents were separated. Staff later witnessed the resident demonstrating inappropriate sexual behaviour towards a third co-resident. The residents were separated, and staff brought the resident to a common area. The resident then demonstrated inappropriate sexual behaviours towards a fourth co-resident in the common area.

Multiple staff members identified sexual abuse occurred between the resident and the other four residents. An RPN reported that one of the four residents was upset for many days after the incident. Registered staff identified that the four residents were touched inappropriately without consent.

Sources: CIS report #M586-000019-21, residents' clinical records, and interviews with BSO Lead and other staff. [s. 19 (1)] (708239)

WRITTEN NOTIFICATION RESPONSIVE BEHAVIOURS

NC#06 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 53 (4) (b)

The licensee has failed to ensure for the resident who demonstrated responsive behaviours, strategies were developed and implemented to respond to their behaviours.

Rationale and Summary
The resident had a history of inappropriate sexual behaviours and identified as having a history of touching others inappropriately.

Due to the history of inappropriate sexual behaviours, staff implemented several interventions, including specific intervention provided for the resident in their room, and close monitoring of the resident when in the common areas and ensuring safe distance between other residents.

The resident was assessed by an external behaviour support team who identified that the resident exhibited sexual expression and touching that would not be easily altered and needed to apply firm and consistent approach. Among the recommendations was to engage the resident in activities that they were interested in or advised to rest in their room. Another external provider assessed the resident and recommended continued behavioural support team involvement to develop a care plan to help reduce risk to other residents.

On a specific date, the resident displayed sexually inappropriate behaviour towards four residents.

An RPN reported that they separated the resident from the other residents and provided redirection. They did not attempt to bring the resident back to their room until after the incident involving the fourth resident.

BSO Lead reported that strategies outlined in the resident's written plan of care including a specific intervention and redirection back to their room should have been implemented. They expected staff to remove the resident from the common area and redirect the resident to their room after the first incident. They identified that multiple incidents would not have occurred if close monitoring was provided.

Sources: the resident's clinical notes, and interviews with registered staff and other staff. [s. 53 (4) (b)] (708239)

WRITTEN NOTIFICATION PLAN OF CARE

NC#07 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 , s. 6 (10) (b)

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

Rationale and Summary

The resident's written plan of care related to inappropriate sexual behaviour instructed staff not to seat the resident next to or near residents of a specific gender.

There were incidents of sexual abuse towards residents of both genders on a specific date.

The home's clinical lead and BSO Lead, reported that the resident displayed inappropriate sexual behaviours towards residents of both genders. After the above-mentioned incidents, the written plan of care should have been updated to reflect this change.

Failure to review and revise the plan of care when the resident's care needs changed had the potential of increased risk of co-residents not being protected from inappropriate sexual behaviour.

Sources: the resident's clinical records, and interview with the home's clinical lead and other staff. [s. 6 (10) (b)] (708239)

WRITTEN NOTIFICATION REPORTING AND COMPLAINTS

NC#08 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, *s. 24 (1) 2.*

The licensee has failed to ensure a person who had reasonable grounds to suspect that sexual abuse of a resident occurred, immediately reported the suspicion and the information upon which it is based to the Director.

Rationale and Summary

On a specific date, a resident was found in a co-resident's bedroom demonstrating a specific behaviour.

An RPN suspected sexual abuse to have occurred given the resident's history of inappropriate sexual behaviour and felt it was inappropriate for the resident to raise up another resident's clothing. The other resident was asleep at the time and could not give consent. The DOC reported that the suspicion of sexual abuse was not communicated to them. The home's management team was responsible to report incidents of suspected abuse to the Director. A report to the Director regarding the suspected resident to resident sexual abuse was not made by the home.

Sources: the residents' clinical records, interview with an RPN and other staff. [s. 24 (1) 2.] (708239)