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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
Telephone: 1-866-311-8002
TorontoSAO.moh@ontario.ca

Original Public Report

Report Issue Date September 13, 2022
Inspection Number 2022_1590_0002
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

Lead Inspector
Slavica Vucko (210)

Additional Inspectors
Goldie Acai (741521), Manish Patel (740841)

Inspector Digital Signature
Slavica Vucko
Digitally signed by Slavica Vucko
Date: 2022.09.16 13:39:49 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): Aug 15, 16, 17, 18, 19, 22, 23 and 24, 2022.

The following intake(s) were inspected:

- #013389-22 Critical Incident System (CIS) report related to hospitalization and significant change in resident's health status, in relation to
- #013411-22 (Complaint) related to an accident which resulted in injury and hospitalization of a resident

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Recreational and Social Activities
- Resident Care and Support Services

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

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NC#01 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 s. 102 (2) b

The licensee has failed to ensure any standard or protocol issued by the Director with respect to infection prevention and control (IPAC) was implemented.

The "Infection Prevention and Control Standard for Long Term Care Homes April 2022" (IPAC Standard), directs homes to follow the Minister's Directive: COVID-19 Provincial Testing Guidance, Issued June 15, 2022, related to rapid antigen testing.

During surveillance testing of staff and visitors for COVID-19, the rapid antigen test (RAT) was not performed as per the manufacturer's instructions. Swabs were supposed to be left in the collection tube for at least two minutes before adding three drops of the liquid into the testing device. Observation showed staff did not keep the swabs for two minutes in the collection tube before adding three drops of the liquid in the testing device.

Staff was provided with education by the IPAC Practitioner on proper techniques of how to use the equipment and performed subsequent tests properly.

Sources: observation, rapid antigen testing kit instructions, interview with the IPAC practitioner.

Date Remedy Implemented: August 17, 2022
[741521]

NC#02 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 s. 102 (8)

The licensee has failed to ensure that all staff participated in the implementation of the program.

The "IPAC Standard for Long Term Care Homes April 2022" provides guidance for staff to follow IPAC routine practices and additional precautions. Specifically, proper use of PPE, including appropriate selection, application, removal, and disposal as required by Additional Requirement 9.1 (d) under the IPAC Standard.

Two units were on COVID-19 outbreak and the staff were expected to wear N95 masks and face shields as per Public Health recommendations for additional precautions.

A staff member was observed to be wearing a surgical / procedural mask instead of N95 mask. The staff replaced the mask immediately, donning an N95 mask.

Additional observation showed two staff who were wearing an N95 mask but did not have their masks properly sealed on their face.

Staff members were provided with education by IPAC Practitioner regarding how to properly seal the N95 mask and the staff corrected the N95 mask seal.

On August 18, 2022, the above mentioned staff were observed having properly fitted N95 masks.

Sources: observations, interview with the IPAC Practitioner.

Date Remedy Implemented: August 18, 2022

[740841, 741521 and 210]

COMPLIANCE ORDER [CO#001] RECREATION AND SOCIAL ACTIVITIES

NC#03 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021, s. 14. (1)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA, 2021, s. 14. (1)]

The Licensee has failed to comply with FLTCA, 2021, s. 14. (1)

The Licensee shall:

1. Review the home's policy on community outings with staff involved in outings and any other staff involved in the Recreation and Social Activities program by the compliance due date.

2. Maintain a record of the policy review, to include staff names, dates and person responsible for reviewing the policy with staff.

3. For any outings prior to the compliance due date, the designated outing lead has reviewed any safety risks, and mitigation strategies, with the Manager of Resident Services and advised all outing staff prior to departing the home.

4. Maintain a record for a period of six months of all community outings, to include, but not be limited to: date, location, outing lead, staff in attendance and review of safety risks with the Manager of Resident Services.

Grounds

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Non-compliance with: FLTCA, 2021, s. 14. (1)

The licensee has failed to ensure that the home's policy for the organized program of recreational and social activities was complied with.

As per O. Reg 246/22 s. 34. (1) every licensee of a long-term care home shall ensure that there is a written description of the recreational and social activities program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes.

The home's policy Community Outings, indicated a procedure for pre-programing that stated: The Outing Lead to be responsible for coordinating and taking the lead of the outing. The Outing Lead shall contact destination to ascertain suitability of the venue (i.e. number of steps involved, location of restrooms, parking, elevators, exits, seating arrangements, refreshments, expected crowds, time, tour guides, safety precaution, accessibility for the handicapped, and the best route to travel).

The home organized four outings to a venue in the community. During the first outing RSA #119 was the Outing Lead. RSA #119 followed a specific route at the location that was evaluated by them to be safe for residents with wheelchairs and walkers. The terrain used was flat and without a slope, downhill or uphill. Other two staff followed the directions from RSA #119 during the outings.

During the fourth outing, RSA #120 was the Outing Lead accompanied by another staff to the location. They did not contact the destination or consult colleagues who visited the location previously to ascertain safest route. RSA #120 did not contact the destination before the outing as per the Community Outings policy direction.

Upon arrival to the location, RSA #120 took three residents to have a tour of the location. RSA #120 headed towards a pathway with a slope. During transportation of one resident, RSA #120 was unable to control the resident's descent and lost control of the resident's ambulation device. RSA #120 lost their balance and fell. The wheelchair was released from their hands. The resident sustained injuries and was transported to hospital where they later passed away.

RSA #121 indicated that when taking residents on outing, they would familiarize themselves with the location, first by asking their colleagues, and phoning the location.

During the fourth outing, there was no communication with the destination, between Outing Leads, or the Manager of Resident Services to ascertain suitability and safety of the routes.

Staff #127 indicated that when on an outing a flat pathway should be selected for resident safety. On a sloped pathway, a resident in a wheelchair could roll away uncontrolled causing potential fall and injury.

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Failure to comply with the home's policy for community outings led to actual harm of one resident and potential risk to others.

Sources: review of the Critical Incident system (CIS) report, the venue's incident report, home's policy Community Outings RS-0606-00, resident clinical record, hospital report, interviews with staff and police, visitation of the location of incident**.**
[210]

This order must be complied with by October 21, 2022

REVIEW/APPEAL INFORMATION

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

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include,

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

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

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

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

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the

purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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

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

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

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