Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002
torontodistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: January 12, 2023	
Inspection Number: 2022-1590-0005	
Inspection Type: Complaint	
Licensee: City of Toronto	
Long Term Care Home and City: True Davidson Acres, Toronto	
Lead Inspector April Chan (704759)	**Inspector Digital Signature** April W Chan Digitally signed by April W Chan Date: 2023.01.13 15:13:43 -05'00'

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 15- 16, 19-21, 2022

The following intake(s) were inspected:

- Intake: #00014308 related to multiple care concerns including drug administration and allegation of abuse and neglect.

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

Infection Prevention and Control
Medication Management
Food, Nutrition and Hydration
Resident Care and Support Services
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

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.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that Routine Practices and Additional Precautions were followed in the infection prevention and control (IPAC) program by a staff member.

Rationale and Summary
Additional personal protective equipment (PPE) requirements were not followed in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard).

Specifically, the licensee did not ensure that the staff member followed appropriate PPE selection for droplet contact precautions as is required by Additional Requirement 9.1 f) under the IPAC Standard.

The home's policy on droplet precautions states that gloves, mask, gown, protective eye wear must be worn by staff and visitors when within 2 metres of a resident in droplet precautions.

On December 15, 2022, at 1231 hours, a Registered Practical Nurse (RPN) was seen assisting a resident with adjusting their table and head of bed. There was droplet and contact precautions signage posted at door of the resident's room and the RPN entered with only an N95 face mask.

The RPN indicated that the resident was placed on droplet contact precautions, but donning of gown, face shield, and gloves were not required to enter the resident's room because they were negative for COVID-19 infection.

The IPAC lead and a nurse manager (NM) indicated that required PPE that should have been worn were gown, gloves, eye protection and the N95 mask because the resident was placed on droplet and contact precaution. Instructions should have been followed according to the additional precaution signage

posted at the resident's door.

Re-education was provided to the RPN on personal risk assessment, droplet contact precautions, use of eye protection in outbreak areas, donning and doffing of PPE.

There was minimal risk identified when the RPN did not don the required PPE for a resident under droplet and contact precautions.

Sources: the home's policy "Droplet Precautions" (Published January 3, 2020), observations on December 15, 2022, interviews with an RPN, IPAC lead and NM.

Date Remedy Implemented: December 15, 2022.

[704759]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that cleaning and disinfection related to additional precaution procedures of the IPAC program were followed by a staff member.

Cleaning and disinfection of eye protection were not followed in accordance with the IPAC Standard. Specifically, the licensee did not ensure that a personal support worker (PSW) followed appropriate cleaning and disinfection procedures of their face shield as is required by Additional Requirement 5.3 h) under the IPAC Standard.

Rationale and Summary
On December 15, 2022, at 1255 hours, the PSW did not remove their face shield to clean and disinfect immediately after care of a resident who was symptomatic for an infection. They continued to another resident's room to collect a meal tray.

The PSW acknowledged that the resident had an infection and that they should have cleaned and disinfected their face shield outside the resident's door but had not done so until they went to the nursing station. The home's expectation for staff members upon exiting a resident's room with a specific infection or finished providing care to a group of residents with a specific infection, was to clean and

disinfect the face shield for re-use outside the resident's door.

There was risk identified when a staff member did not clean and disinfect their eye protection outside the door of a resident with an infection.

Sources: observations on December 15, 2022, interviews with the PSW, the IPAC lead and NM.

[704759]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (4) (a)

The licensee has failed to ensure that staff and others involved in different aspects of care of a resident collaborate with each other in the assessment of the resident's behavioural expression.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 6 (4) (a) of O. Reg. 79/10/LTCHA.

Rationale and Summary
The resident was seen by an external behavioural support consultant on a specific date before April 11, 2022, who recommended additional pharmacological review by a psychiatrist for the resident's specific medication. Behaviour Support Ontario (BSO) lead indicated that the resident was not referred to an external psychiatrist and there were no further clinical notes relevant to the recommendations for the specific medication.

BSO lead indicated that they should have received a copy of the recommendations from the external behavioural support consultant, but that was not received and thus they did not follow-up on the recommendation. A registered nurse (RN) and BSO Lead indicated that the recommendations on the resident's progress notes would appear on the nursing shift report and that registered staff had the ability to follow-up on recommendations with the BSO Lead or the home's physician.

Sources: the resident's progress notes, medication administration records, prescriber orders, interviews

with an RN, BSO lead and NM.

[704759]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (e) (i)

The licensee has failed to ensure the weight monitoring system to measure and record a resident's weight was complied with.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that there is a weight monitoring system to measure and record each residents' weight on admission and monthly thereafter and must be complied with.

Specifically, staff did not comply with the home's policy "Nutrition and Hydration Program", dated August 15, 2021, where the PSW was responsible to measure and record the resident's weight, and to reweigh the resident and record the new weight if there is a 2 kilogram (kg) change in weight.

Rationale and Summary
The resident had weighed a specific amount, and weighed a difference greater than 2 kg one month later. There was no further record of reweigh.

A PSW indicated that the difference in weight for the resident was greater than 2 kg and the resident should be reweighed but that was not done. They indicated that the registered staff was responsible to determine if the resident requires a reweigh.

A NM indicated that the PSW was responsible to compare the resident's weight for differences, and that the registered staff was responsible to double check.

There was risk identified when staff did not comply with the home's policy to reweigh the resident.

Sources: the home's policy "Nutrition and Hydration Program" (dated August 15, 2021), the resident's clinical records, and interviews with a PSW, a NM, and other staff members.

[704759]

WRITTEN NOTIFICATION: Medication Management System

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)

(i) The licensee has failed to comply with the policies of the medication management system to ensure date, time and who provided consent for new medication or medication with change in directions for the resident's was documented.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that there is a medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home and must be complied with.

Specifically, the home did not comply with the policy "Medication Administration", dated January 12, 2019, where staff should document date, time and who provided consent beside the medication order.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 114 (2) of O. Reg. 79/10/LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 123 (2) of O. Reg. 246/22 under the FLTCA.

Rationale and Summary
The resident was prescribed a specific medication on a specific date before April 11, 2022, and another medication on a specific date after April 11, 2022. The prescriber orders for both medications showed that consent documentation was not done. Review of the resident's progress notes did not show consent was documented on the specific dates when medication was prescribed.

An RN indicated that the registered nursing staff or the home's physician call for consent and should document within the resident's progress notes, but that the documentation was not done on the resident's progress notes. A NM indicated that consent for new medication or medication with change in directions was done for the resident but not documented.

Sources: the home's Medication Administration policy (dated December 01, 2019) the resident's clinical notes, prescriber orders, interviews with an RN and a NM.

[704759]

(ii) The licensee has failed to comply with the policies of the medication management system to ensure the resident's drug records was kept for a period of three years.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that there is a medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home and must be complied with.

Specifically, the home did not comply with the policy "Pharmacy policy and procedure manual for LTC homes", dated February 2017, where the drug record is kept in the home for at least three years.

Rationale and Summary
The resident was prescribed monitored medications.

The combined monitored medication record with shift counts for the resident showed that drug records ended on a specific date and time. There were no record of shift counts after the specific date and time.

An RPN indicated that the combined monitored medication record with shift counts was done for the resident, but the documentation was not appropriately filed from the medication book to the resident's chart and went missing. A NM indicated the medication record with shift counts should have been kept in the resident's chart, but the records could not be found.

Sources: the home's Pharmacy Policy & Procedure manual for LTC homes titled The Drug Record (February 2017), the resident's combined monitored medication record with shift counts, medication administration records, and interviews with an RPN and a NM.

[704759]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)

The licensee has failed to ensure policies and procedures relating to referral to a dietitian for nutritional care and hydration for a resident was complied with.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure nutritional care and hydrations programs include the implementation of policies and procedures relating to nutritional care and must be complied with.

Rationale and Summary
The home's policy on Referral to the Dietitian states that the registered nurse or registered practical nurse is responsible to contact the registered dietitian by phone for unmanaged high nutritional risk to communicate assessment and co-ordinate date for Dietitian to complete assessment.

Reasons for referral to the dietitian include refusal to eat or drink more than three consecutive meals and change from usual pattern in food or fluid intake for two of the three meals over a period of seven days.

A PSW indicated that the resident's food and fluid intake was communicated to the nurse in charge daily. The resident's clinical notes indicate that the resident refused meals and supplements, and the medication administration records showed that the resident refused supplements. The resident's response rate for meal refusal between a specified period of time, was a higher percent compared to when the resident moved in. A Registered Dietitian (RD) indicated that the resident's food and fluid intake declined during the specified period of time.

The RD indicated that a referral for the resident should have been sent by registered staff when the resident's food and fluid intake declined and when supplements were refused but did not receive a referral.

A NM acknowledged that staff were expected to send a referral for dietitian for the resident.

There was risk identified when a referral to the dietitian was not sent for the resident when food and fluid intake declined.

Sources: the resident's medication administration record, clinical records and clinical assessments, interviews with a NM and other staff members.

[704759]