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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: August 9, 2023	
Original Report Issue Date: July 13, 2023	
Inspection Number: 2023-1590-0007 (A1)	
Inspection Type: Complaint Critical Incident System	
Licensee: City of Toronto	
Long Term Care Home and City: True Davidson Acres,Toronto	
Amended By Susan Semeredy (501)	**Inspector who Amended Digital Signature** Susan L Semeredy Digitally signed by Susan L Semeredy Date: 2023.08.09 13:12:52 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Provide an extension to the compliance due date for Compliance Order #001 from August 25 to September 30, 2023, due to a request from the home.

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Lead Inspector Susan Semeredy (501)	**Additional Inspector(s)** Irish Abecia (000710) Ramesh Purushothaman (741150)
Amended By Susan Semeredy (501)	**Inspector who Amended Digital Signature** Susan L Semeredy Digitally signed by Susan L Semeredy Date: 2023.08.09 13:13:26 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Provide an extension to the compliance due date for Compliance Order #001 from August 25 to September 30, 2023, due to a request from the home.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 26-30 and July 4-7, 2023

The following intakes were completed in this complaint inspection:
Intake: #00089753 – Complaint regarding pest control and housekeeping
Intake: #00091061 - Complaint regarding concerns surrounding a resident's fall

The following intakes were completed in this Critical Incident (CI) inspection:
Intake: #00019800 - M586-000005-23 - Episode of hypoglycemia with glucagon administered

Intake: #00021579 - M586-000006-23 - Alleged physical abuse from staff towards a resident
Intake: #00022146 - M586-000008-23 - Fall of resident
Intake: #00022540 - M586-000010-23 - Potential neglect from staff towards a resident
Intake: #00022779 - M586-000011-23 - Improper/Incompetent care of a resident
Intake: #00089497 - M586-000015-23 - Suicide attempt of resident

The following intakes were completed in this complaint inspection:
Intake #00015245, M586-000034-22 and Intake #00085355, M586-000012-23 were related to falls

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that the written plan of care provided clear directions to staff.

Rationale and Summary
A resident's care plan indicated that they required the use of equipment to prevent an injury from a fall. The progress notes revealed that the resident no longer required this as the resident was not a risk for falls anymore.

Staff members confirmed that the resident did not require the use of this equipment and confirmed that the staff knew this intervention was no longer required. The Director of Care (DOC) spoke with the Resident Assessment Instrument (RAI) Coordinator and confirmed that the care plan had not updated since July 2020.

Sources: Critical Incident Report (CIR), a resident's clinical records and interviews with staff. [741150]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

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

Rationale and Summary
A resident returned from the hospital after an incident that required interventions to ensure safety. This included providing the resident with dietary interventions as stated on their care plan. The resident was observed without these dietary interventions during a meal service. A Food Services Worker confirmed that the meal distribution report indicated that the resident was to be provided with these interventions.

Interviews with Personal Support Workers (PSWs) indicated that the resident was provided with alternatives since they were supervised by staff during meal service. An RPN stated that the resident refused dietary interventions indicated on their care plan and therefore was not provided such. The Nutrition Manager confirmed that they did not receive a referral from the staff indicating that the interventions for the resident regarding the use of these dietary interventions were no longer applicable. The DOC verified that a written or verbal referral should have been initiated to collaborate with the interdisciplinary team when there were changes to resident's plan of care.

Failure to collaborate with the interdisciplinary team in the development and implementation of the plan of care increased the possibility for inconsistent provision of care to the resident which may risk further harm to the resident.

Sources: Observation; Resident's care plan and meal distribution report; Interviews with the Nutrition Manager and other staff. [000710]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

(i) The licensee has failed to ensure that a resident was provided care as set out in the care plan.

Rationale and Summary
A resident required an intervention to prevent skin breakdown. The home had initiated an internal investigation following an unrelated incident and when they viewed the camera footage, it was revealed that a PSW did not assist the resident with any care for several hours. An RPN and the DOC confirmed that the PSW did not provide the care as specified in their care plan.

Failure to ensure the care set out in the plan of care a resident put them at risk for skin breakdown.

Sources: CIR, a resident's clinical records, and interviews with an RPN and other staff. [741150]

(ii) The licensee has failed to ensure a resident was provided monitoring as specified in the plan of care.

Rationale and Summary
A resident required monitoring to manage responsive behaviours. The resident was found to have engaged in unsafe behaviour. An RN stated that a staff member that was to be monitoring the resident was not found to be in an area where they could view the resident.

The DOC confirmed that the expectation of such staff was they were to be present with the resident and monitor them closely.

Failure to ensure monitoring was provided to the resident resulted in the resident having harmed themselves.

Sources: CIR, a resident's clinical records, and interviews with an RN and other staff. [741150]

WRITTEN NOTIFICATION: ADMINISTRATION, MISCELLANEOUS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure compliance with the Minister's Directive: Glucagon, Severe Hypoglycemia, and Unresponsive Hypoglycemia, updated April 11, 2022.

In accordance with the Minister's Directive: Glucagon, Severe Hypoglycemia, and Unresponsive Hypoglycemia, the licensee was required to ensure that the Director was informed of a resident who was administered glucagon which resulted in the resident being taken to a hospital no later than one business day, followed by the report. The licensee was also required to ensure that all uses of glucagon were reviewed and analyzed, corrective action was taken as necessary, and a written record was kept of everything.

Rationale and Summary
An RN documented that a resident's blood sugar was low. Glucagon was then administered to the resident and the resident was subsequently sent to the hospital for further evaluation.

According to the home's policy titled, Management of Hypoglycemia, a resident incident form is completed for any and all use of glucagon, severe hypoglycemia or unresponsive hypoglycemia events. The RN confirmed that they had received training on the home's policy related to the management of hypoglycemia, and was aware of reporting requirements to the home and Director. However, the DOC confirmed that the resident incident form was not completed for this incident related to the administration of glucagon. Consequently, the home did not inform the Director of the incident.

Sources: Resident's progress notes, Minister's Directive: Glucagon, Severe Hypoglycemia, and Unresponsive Hypoglycemia, updated April 11, 2022 and home's policy titled Management of Hypoglycemia, Section 02 – Medication Administration, MM-0206-00, published September 15, 2022; Interviews with an RN and the DOC. [000710]

COMPLIANCE ORDER CO #001 Care Plans and Plans of Care

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 19.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Conduct an interdisciplinary review of five residents at high risk for falls to ensure the plan of care includes all interventions to keep the residents safe.
2. Ensure the plan of care for these residents highlights any particular safety risks.
3. Develop and implement a method to communicate these safety risks to direct care staff especially to those staff that might be unfamiliar with the residents including, but not limited to, newly hired staff, casual staff and those that have moved units.
4. Document the above activities and make available to inspector upon request.

Grounds
The licensee has failed to ensure that the plan of care for a resident was based on an interdisciplinary assessment with respect to safety risks.

Rationale and Summary
A resident had a fall and sustained an injury.

On the day of the fall, a PSW was providing care for the resident who was unaware of the resident's history of falls. They were shocked that the resident fell in the manner in which they were found. There was a history of similar falls. Some of these falls resulted in injury.

Other PSWs verified they knew the resident tended to fall in this manner. A physiotherapist (PT) indicated that staff who did not know the resident, may not have thought they could fall in this manner whereas, the regular staff would have known. A Nurse Manger acknowledged that the staff providing care to this resident were not used to the resident's manner in which they would fall.

The home failed to assess the resident's risk for falling in a specific manner and to put interventions in place to keep the resident safe.

Sources: CIR, the resident's progress notes and care plan. Interviews with PSWs, a PT and a Nurse Manager. [501]

This order must be complied with by September 29, 2023

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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) 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:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) 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
e-mail: 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.