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

# Original Public Report

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| **Report Issue Date:** November 7, 2023 |
| **Inspection Number:** 2023-1590-0008 |
| **Inspection Type:**<br>Critical Incident<br>Follow up |
| **Licensee:** City of Toronto |
| **Long Term Care Home and City:** True Davidson Acres, Toronto |

| **Lead Inspector** | **Inspector Digital Signature** |
|---|---|
| Susan Semeredy (501) | Susan L Semeredy<br>Digitally signed by Susan L Semeredy<br>Date: 2023.11.07 12:28:48 -05'00' |

**Additional Inspector(s)**

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 24, 26, 27, 30, 31, 2023 and November 1, 2023

The following intake was inspected in this Follow-up inspection:

- Intake #00092256- Follow-up to compliance order #001 from inspection #2023-1590-0007 and was related to safety risks and falls prevention

The following intakes were inspected during this Critical Incident (CI) inspection:

- Intake #00092941/M586-000020-23 was related to the unexpected death of a resident
- Intake #00093061/M586-000021-23 was related to responsive behaviours of a resident

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1590-0007 related to O. Reg. 246/22, s. 29 (3) 19. inspected by Susan Semeredy (501)

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

Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

# 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 (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**
Progress notes indicated that a resident's care needs changed related to the progression of a disease. The resident was known to have personal assistive service devices (PASDs) which had been assessed when the resident was first admitted.

An RN indicated that due to the resident's change in condition, the staff had been implementing some interventions so that the resident would not injure themselves. The resident's plan of care indicated there were no interventions related to this change. As well, the use of PASDs had not been reassessed since admission. A Nurse Manager confirmed that the resident's plan of care needed to be reviewed related to the resident's disease progression and that the OT needed to reassess the risk and benefit of the use of these PASDs.

Failing to reassess and review a resident's plan of care put them at risk for injury.

**Sources:** A resident's progress notes, care plan and assessments, an observation and interviews with an RN and other staff. [501]

## WRITTEN NOTIFICATION: Reporting and Complaints

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.

The licensee has failed to ensure that the Director was immediately informed of the unexpected death of a resident.

**Rationale and Summary**
A Critical Incident (CI) report indicated a resident died unexpectedly and the home first submitted the information to the Director the next day. There was no communication made to the after-hours line to report this incident. The Director of Nursing (DON) acknowledged that this unexpected death was not immediately reported.

**Sources:** CI report and an interview with the DON. [501]