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

# Original Public Report

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| **Report Issue Date:** June 20, 2024 |
| **Inspection Number:** 2024-1590-0003 |
| **Inspection Type:**<br>Complaint<br>Critical Incident |
| **Licensee:** City of Toronto |
| **Long Term Care Home and City:** True Davidson Acres, Toronto |

| **Lead Inspector** | **Inspector Digital Signature** |
|---|---|
| Britney Bartley (732787) | Britney Bartley<br>Digitally signed by Britney Bartley<br>Date: 2024.07.08 09:39:37 -04'00' |

**Additional Inspector(s)**

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 28 - 31, 2024 and June 3 - 5, 7, 10, 2024

The following intake(s) were inspected:

- Intake: #00111009 - Fall of resident with injury.
- Intakes: #00113597 & #00116398 – Complainants related to a resident's discharge.
- Intake: #00113713 - Use of a specified medication on a resident.
- Intake: #00116103 – A complainant related to alleged abuse.

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

Resident Care and Support Services
Medication Management

Infection Prevention and Control
Falls Prevention and Management
Admission, Absences and Discharge

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Requirements on licensee before discharging a resident

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 161 (2) (c)**

Requirements on licensee before discharging a resident

s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,

(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that their wishes are taken into consideration.

The licensee has failed to ensure that before discharging a resident under subsection 157 (1) that the resident and the resident's substitute decision-maker (SDM) is kept informed and given an opportunity to participate in the discharge planning and that their wishes are taken into consideration.

**Rationale and Summary**

A Registered Practical Nurse (RPN) and the Behavioural Support Ontario (BSO) Nurse indicated a resident had a few incidents with staff in the home. The resident was placed on an intervention, transferred to a hospital, and was discharged from the home a few days later.

The Administrator indicted before the date of discharge the home did not give the SDM's an opportunity to participate in the discharge planning and that their wishes were not taken into consideration.

In review of the resident's clinical health record there was no documentation demonstrating any discussion had occurred with the resident's SDM before the discharge date.

Failure to ensure that the resident SDM was able to participate with the discharge planning, may have negatively impacted their ability of finding appropriate supports, as well as the ability to express their wishes regarding their discharge.

**Sources:** A resident's clinical records, interviews with RPN, BSO, the Administrator and other staff.

[732787]