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

Report Issue Date: July 11, 2024
Inspection Number: 2024-1590-0004
Inspection Type: Critical Incident
Licensee: City of Toronto
Long Term Care Home and City: True Davidson Acres, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: June 25, 27, 2024
The inspection occurred offsite on the following date: June 28, 2024

The following intake was inspected:

- Intake: #00118920 - Critical Incident Systems (CIS) #M586-000021-24 - Allegation of resident to resident physical abuse

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

COMPLIANCE ORDER CO #001 Altercations and other interactions between residents

NC #001 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with [FLTCA, 2021, s. 155 (1) (b)]:
The licensee shall prepare, submit and implement a plan to ensure staff are implementing and identifying interventions to manage a resident's responsive behaviours and minimize the risk of altercations and potentially harmful interactions between and among residents.

The plan shall include but is not limited to:
1. How staff will document and record all trialed interventions to manage the resident's responsive behaviours and along with their effectiveness;
2. A communication plan amongst the home's staff related to implementing interventions for the resident's responsive behaviours. This communication plan should include, but not limited to, who was involved, interventions discussed, and rationales as to why interventions/approaches will be used or not used;
3. Training to all direct care nursing staff (including but not limited to Registered Nurses, Registered Practical Nurses and Personal Support Workers) who work with the resident related to their responsive behaviour interventions;
4. A review of all responsive behavioural incidents of a resident from a specified period, by, but not limited to, the Acting Nurse Manager and the BSO Lead to determine if additional behavioural interventions are required. This review must be

documented on the dates it was completed and who attended the review; and
5. The person(s) who will be responsible for steps one through three and when it will be completed, if applicable.

Please submit the written plan for achieving compliance for inspection #2024-1590-0004 to LTC Homes Inspector, MLTC, by email to torontodistrict.mltc@ontario.ca by July 30, 2024.
Please ensure that the submitted written plan does not contain any PI/PHI. This plan shall be implemented by the compliance due date: September 13, 2024.

Grounds
The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between a resident and other co-residents by identifying and implementing interventions.

Rationale and Summary:
An incident occurred where the resident was involved in an altercation with a co-resident, resulting in injuries on the resident.

The resident's care interventions had changed and the Registered Practical Nurse (RPN) and the Behavioural Support Ontario (BSO) Lead stated that the resident's responsive behaviours escalated after these changes. According to the progress notes, they were involved in a number of responsive behavioural incidents with staff and residents prior to the above mentioned incident, but there were no referral to the BSO Lead and/or identification or implementation new interventions in a number of these incidents.

The BSO Lead stated that they had attempted various interventions with the resident but that they were ineffective. The BSO Lead also added that they would

have wanted to implement an intervention related to their responsive behaviours but that Acting Nurse Manager (ANM) had indicated it was not necessary.

The ANM stated in their interview that they did not witness the resident engaged in responsive behaviours towards others but confirmed they had demonstrated responsive behaviours. The ANM stated the BSO Lead could have done more to have prevented the above mentioned incident by implementing other specified interventions, instead of the one suggested by the BSO Lead.

Both the BSO Lead and ANM acknowledged that more interventions could have been identified and implemented for the resident, prior to the incident that had occurred.

Failure to identify and implement interventions for the resident's responsive behaviours, increased the risk of resident to resident altercations.

Sources: A resident's progress notes; Interviews with the BSO Lead, the ANM, an RPN and other staff.

This order must be complied with by September 13, 2024

COMPLIANCE ORDER CO #002 Duty to protect

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

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

1. Protect a resident from physical abuse from another resident.
2. Identify and implement behavioural interventions/approaches to minimize physical altercations with other co-residents through an assessment for a resident.
3. Maintain a record of the assessment, interventions and approaches implemented for a resident, including the person(s) who were involved in assessing and implementing interventions and approaches for both residents.

Grounds

The licensee failed to ensure a resident was protected from physical abuse by another resident.

Section 7 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another residents."

Rationale and Summary:
A Personal Support Worker (PSW) found a resident with an injury. Another resident stated they were involved in this incident for a specified reason.

Both resident's care plan indicated that they had both demonstrated responsive behaviours.

The Registered Nurse (RN) who had responded to the incident, believed that the two residents had an interaction and resulted in one of them receiving the injuries.

A Police Detective stated in their interview with the inspector that they had gathered evidence to support that an incident of resident to resident physical abuse had occurred in this incident.

Failure to ensure that appropriate behavioural interventions were in place to mitigate this incident resulted in a resident to be injured by a co-resident.

Sources: Progress notes from a resident; Police Undertaking Form for a resident; Interviews with the BSO Lead, the RN, a Police Detective and other staff.

This order must be complied with by September 13, 2024

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

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.