

**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

## Public Report

**Report Issue Date:** January 13, 2025

**Inspection Number:** 2024-1590-0006

**Inspection Type:**

Complaint  
Critical Incident  
Follow up

**Licensee:** City of Toronto

**Long Term Care Home and City:** True Davidson Acres, Toronto

## INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 6, 7, 8, 9, 10, 2025.

The following intakes were inspected:

- Intake: #00128922 - related to follow-up of compliance order (CO) #001 from inspection #2024-1590-0005;
- Intake: #00129352 - Critical Incident Systems (CIS) #M586-000036-24 - related to an incident of hypoglycemia;
- Intake: #00129351 - CIS #M586-000035-24 - related to an allegation of improper care to a resident;
- Intake: #00129845 - CIS #M586-000037-24 - related to a fall with an injury;
- Intake: #00132651 - related to a complaint regarding withholding approval for admission;
- Intake: #00133434 - CIS #M586-000045-24 - related to an outbreak;
- Intake: #00135195 - CIS #M586-000049-24 - related to an alleged incident of resident abuse.

The following intake was completed:

- Intake: #00136364 - CIS #M586-000001-25 - related to a fall with an injury.

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- Intake: #00136536 - CIS #M586-000003-25 - related to an outbreak;
- Intake: #00134630 - CIS #M586-000047-24 - related to an outbreak.

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1590-0005 related to FLTCA, 2021, s. 6 (7)

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

Continence Care  
Medication Management  
Infection Prevention and Control  
Prevention of Abuse and Neglect  
Falls Prevention and Management  
Admission, Absences and Discharge

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Authorization for admission to a home

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

**Non-compliance with: FLTCA, 2021, s. 51 (7) (b)**

Authorization for admission to a home

s. 51 (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 50 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the

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home unless,

(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or

The licensee failed to demonstrate that staff in the home lacked the nursing expertise to manage an applicant's care requirements. An applicant's admission to the home was withheld due to the licensee indicating their staff lacked the nursing expertise to manage the applicant's care needs. The Behavioural Supports Ontario (BSO) Lead indicated that the staff in the home did have the nursing expertise to manage this applicant's care needs.

**Sources:** Interview with the BSO Lead, the administrator; an applicant's assessments and letter of withholding approval of admission to the home.

## **WRITTEN NOTIFICATION: Authorization for admission to a home**

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 51 (9) (d)**

Authorization for admission to a home

s. 51 (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,

(d) contact information for the Director.

The licensee failed to ensure that the contact information to the Director was provided in the written notice withholding approval of admission to an applicant. The home's letter indicating the withholding of admission to the applicant did not contain the contact information to the Director.

**Sources:** An applicant's withholding admission letter; Interview with the administrator.

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## WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 40**

Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that a Registered Practical Nurse (RPN) and a Personal Support Worker (PSW) utilized safe transferring techniques when assisting a resident. The RPN and PSW performed a transfer with the resident after they sustained a fall. The Nurse Manager (NM) and another RPN stated the transfer assistance provided to this resident was unsafe.

**Sources:** Home's policy titled: No Lift Policy, dated August 2024; a resident's progress notes; interviews with two RPNs and a NM.

## COMPLIANCE ORDER CO #001 Administration of drugs

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**Non-compliance with: O. Reg. 246/22, s. 140 (2)**

Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

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

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1. Provide education to five RPNs on the home's Medication Management Policy and any other relevant policies.
2. Conduct two random audits weekly, on a minimum of two residents, who are diabetic and on insulin to ensure all the required steps were taken for insulin administration. These audits must be conducted for a minimum of four weeks upon service of this order.
3. Maintain a written record of audits conducted, including but not be limited to: date of audit, resident name, staff name(s), and any corrective action taken in response to the audit.
4. Keep a written record of the education provided to staff in step one of this order and ensure the following is included: the person providing the education, date of education provided, and the education content provided.

**Grounds**

The licensee has failed to ensure that a medication that was administered for a resident was in accordance with the directions for use specified by the prescriber.

A resident required to be hospitalized after experiencing a medical emergency. The resident's clinical records indicated that prior to this, a RPN did not administer a resident's medication as per the prescriber's order. Review of the Electronic Medication Administration Records (eMAR) indicated that similar medication incidents had occurred multiple times to the resident, prior to this incident.

Failure to follow the the directions for medication administration as specified by the prescriber put the resident at risk of impact to their medical condition.

**Sources:** CI reports #M586-000035-24 and #M586-000036-24, a resident's clinical records, home's investigation notes, interview with a RPN, and a NM.

**This order must be complied with by** February 25, 2025

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**COMPLIANCE ORDER CO #002 Infection prevention and control  
program**

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)**

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

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

1. Conduct three random audits on a RPN related to the steps of donning and doffing Personal Protective Equipment (PPE). The audits should include the name of the person conducting the audit, when it was done and whether the donning and doffing were done correctly. The audit shall also include details of any follow up actions taken if the RPN did not follow the proper steps of donning and doffing PPE.
2. Keep a written record of the audits for step one of the order.

**Grounds**

The licensee has failed to ensure that a RPN appropriately donned and doffed their personal protective equipment (PPE).

A RPN failed to ensure that they donned and doffed their PPE in accordance with the Infection Prevention and Control (IPAC) Standard. Specifically, the RPN did not ensure they wore a face shield when they entered two residents' rooms who were on precautions and they did not remove their mask when they exited from those residents' rooms, which was part of the home's procedures of properly applying PPE. These two residents had a diagnosis of a respiratory disease.

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Failure to ensure that proper donning/doffing PPE procedures are followed may result in further spread of infectious diseases.

**Sources:** An observation of a RPN; Interview with the RPN and the IPAC Manager home's PPE policy IC-0604-00, published on 01-05-2015, IPAC Standard for long Term Care Homes April 2022, Additional Requirement 9.1.

**This order must be complied with by** February 25, 2025

## 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

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or commercial courier upon:

**Director**

c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8<sup>th</sup> floor  
Toronto, ON, M7A 1N3  
e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto: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



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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, 9<sup>th</sup> Floor  
Toronto, ON, M5S 1S4

**Director**

c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8<sup>th</sup> Floor  
Toronto, ON, M7A 1N3  
e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto: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](http://www.hsarb.on.ca).