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: October 9, 2024

Inspection Number: 2024-1590-0005

Inspection Type:
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: October 1, 2, 3, 9, 2024.

The following intakes were inspected:

- Intake: #00121065 related to follow-up of compliance order (CO) #002 from inspection #2024-1590-0004;
- Intake: #00121066 related to follow-up of CO #001 from inspection #2024-1590-0004;
- Intake: #00123764; Critical Incident System (CIS) report #M586-000029-24 related to a disease outbreak;
- Intake: #00125283; CIS report #M586-000032-24 related to a fall.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2024-1590-0004 related to FLTCA, 2021, s. 24 (1)

inspected by Jack Shi (760)
Order #001 from Inspection #2024-1590-0004 related to O. Reg. 246/22, s. 59 (b)
inspected by Jack Shi (760)

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee failed to ensure that a resident's symptoms were recorded on a specified shift.

Rationale and Summary

A resident was diagnosed with a respiratory illness. A review of the progress notes and assessments section on PointClickCare (PCC) for a specific shift indicated that there was no documentation to support the monitoring of the resident's symptoms during that shift.

The Infection Prevention and Control (IPAC) Manager stated that the staff should document in the progress notes and/or using a specialized assessment tool when monitoring the resident's infectious symptoms. The IPAC Manager confirmed that this process was not followed through on the specified shift.

Failure to document a resident's symptoms may lead to a delay in required treatments.

Sources: Review of resident's progress notes and assessments on PCC; Home's line list of residents affected by the outbreak; Interview with the IPAC Manager.

COMPLIANCE ORDER CO #001 Plan of care

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

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

1. Educate a PSW on what they should do if they notice at any point that a resident does not have their fall prevention interventions in place.

2. Conduct once daily audits on two residents residing on the first floor west side unit who use a specified fall prevention intervention as per their plan of care and ensure that they are in place for a period of two weeks. The audits should include the name of the person conducting the audit, when it was done, the resident's name and room number and whether they were in place or not. The audit shall also include details of any follow up actions taken if the fall prevention intervention was noted not to be in place.
3. Keep a written record of the education and audits for steps one and two of the order; for the education, ensure the following is included- the person providing the education, when it was done and the education content provided.

Grounds

The licensee failed to ensure a resident's plan of care was provided to the resident, related to their use of a fall prevention intervention.

Rationale and Summary

A resident sustained a fall and diagnosed with an injury. According to the resident's care plan at the time of the fall, they were to have a specific intervention in place as part of their fall prevention interventions.

The resident had sustained a number of previous falls, and assessments completed after these falls deemed the resident at high risk for falls and fall related injuries.

A Registered Nurse (RN) stated that the resident did not have their intervention in place when they sustained their fall that resulted in an injury. A Personal Support Worker (PSW) stated they had informed the registered staff days before this incident that the resident did not have this intervention available and did not receive this intervention from the registered staff. The RN stated they did not recall getting

any information from the PSW about this intervention not being available for this resident.

A Nurse Manager (NM) stated they were unaware that this resident did not have their fall prevention intervention in place at the time of their fall with injury. The NM stated that the resident was deemed at high risk for fall related injuries because of the number of falls the resident had sustained and a specific diagnosis.

Failure to ensure that the resident had their fall prevention intervention in place increased the risk of injury to the resident following their fall.

Sources: Review of the resident's clinical chart on PCC including their care plan, progress notes and assessments; Interview with a RN, a PSW and the NM.

This order must be complied with by November 22, 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
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.