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
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Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Public Report

Report Issue Date: April 2, 2025

Inspection Number: 2025-1590-0001

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 date(s): March 20, 24-28, 2025 and April 1-2, 2025
The inspection occurred offsite on the following date(s): March 31, 2025

The following intake(s) were inspected:

- Intake: #00137000 - Follow-up on a previously issued Compliance Order (CO) related to Administration of Drugs
- Intake: #00137001 - Follow-up on a previously issued CO related to Infection Prevention and Control (IPAC) Program
- Intake: #00140070 - Was a complaint related to improper care, and safe and secure home
- Intake: #00140125 - Critical Incident (CI) #M586-000007-25 was related to fall with injury
- Intake: #00141539 - CI #M586-000009-25 was related to a disease outbreak

The following intake(s) were completed:

- Intake: #00136395 - CI #M586-000002-25 was related to fall with injury
- Intake: #00139696 - CI #M586-000006-25 was related to a disease outbreak

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1590-0006 related to O. Reg. 246/22, s. 140 (2)
Order #002 from Inspection #2024-1590-0006 related to O. Reg. 246/22, s. 102 (2) (b)

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

Medication Management
Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Home to be safe, secure environment

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee failed to ensure that the home was a safe and secure environment for its residents.

According to Long-Term Care (LTC) Home Design Manual 2015, "There must be

securely fastened grab bars at every toilet that is within the resident's easy reach."

One of the washrooms in the LTC home did not have an easily accessible grab bar installed beside the toilet, which made it difficult for a resident to stand after using the washroom. The Maintenance Manager confirmed that a grab bar had not been installed beside the toilet within easy reach, making it unsafe for residents.

Sources: Ministry of Health and Long-Term Care Home Design Manual 2015, interview with the Maintenance Manager and the Director of Nursing (DON).

[741672]

WRITTEN NOTIFICATION: Dealing with complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. ii. B.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
ii. an explanation of,
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and

The licensee failed to ensure that the response provided to a resident's Power of Attorney (POA), who had made a written complaint, included the reasons why the complaint was unfounded.

A written complaint was submitted to the LTC home reporting an improper care to a resident. The response to the complaint indicated the complaint was unfounded,

without including the reasons why the complaint was unfounded. The Administrator confirmed that the reasons the complaint was unfounded were not provided.

Sources: Email sent from resident's POA, and the home's response; Interview with the Administrator

[741672]

WRITTEN NOTIFICATION: Complaints — reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 111 (1)
Complaints — reporting certain matters to Director
s. 111 (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 28 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 108 (1).

The licensee failed to submit a copy of a written complaint that was made by a resident's POA, to the Director along with the response the licensee made to the complainant.

Sources: LTC Homes portal, interview with the Administrator

[741672]

WRITTEN NOTIFICATION: CMOH and MOH

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all applicable directives or recommendations issued by the Chief Medical Officer of Health (CMOH) were followed by the home, in relation to alcohol-based hand rub (ABHR).

Specifically, ABHR must not be expired as required by 3.1 IPAC Measures under Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective April 2024. An expired hand sanitizer was offered to residents at meal time in one of the resident home areas. A Registered Practical Nurse (RPN) confirmed that they did not check the expiry date of the hand sanitizer before it was offered to the residents.

Sources: An observation and interview with a RPN and the IPAC Manager.

[741672]