Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 21, 2018	2018_514566_0006	007063-16	Complaint

Licensee/Titulaire de permis

City of Toronto
55 John Street Metro Hall, 11th Floor TORONTO ON M5V 3C6

Long-Term Care Home/Foyer de soins de longue durée

True Davidson Acres
200 Dawes Road TORONTO ON M4C 5M8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ARIEL JONES (566)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 17, 18, 19, 30, 31, August 1 and 2, 2018.

During the course of the inspection, the inspector(s) spoke with the Medical Director, Director of Care (DOC), RAI-Coordinator, registered nursing staff (RN/RPN), personal support workers (PSW), and family members.

During the course of the inspection, the inspector(s): observed the delivery of resident care and services, observed staff-to-resident interactions, reviewed residents' health care records, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Medication
Personal Support Services
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following was documented: the provision of

the care set out in the plan of care.

The Ministry of Health and Long-term Care (MOHLTC) received a complaint from an identified date in February 2016, that outlined care-related concerns involving resident #001, concerns regarding a specific medication, concerns associated with an identified incident, concerns regarding the home's process for transferring residents to hospital, and issues with the resident's attending physician.

A review of resident #001's progress notes from November 2015 to February 2016 indicated that the resident was assessed by an identified specialist in hospital and as of a specific date in November 2015, required an identified type of care to be performed at specified intervals. Review of the resident's written care plan on Goldcare from an identified date in December 2015, indicated one staff does the identified care at the specified intervals.

A review of resident #001's nursing and personal care record (NPCR) flow sheet documentation for November and December 2015, identified incomplete documentation for the provision of the identified care at the following times:
AM: 10 occasions,
PM: 29 occasions, and
BT: 5 occasions.

Interviews with RPNs #102 and #107 indicated that resident #001's identified care interventions changed following their hospitalization in November 2015, to include provision of the identified care at specified intervals. Interviews with PSW #108 and RPN #102, who both worked with resident #001 in November and December 2015, indicated that the resident did receive the identified care daily at the specified intervals, according to their plan of care, however sometimes staff are busy and forget to document. RPN #102 clarified that according to the flow sheet for the identified care, AM referred to morning care, PM was in the afternoon around lunch time, and BT was bedtime. RPN #102 stated further that based on the resident's care needs, staff were expected to complete the documentation under all three areas for the provision of the identified care on the flow sheet for each date. RPN #102 confirmed that based on the home's policy, all care provided should have been documented.

During an interview, the DOC stated that if resident #001 required the identified care at the specified intervals, staff were required to complete the documentation in all three areas of the NPCR record (AM, PM, and BT) when the care was provided.

A review of resident #001's NPCR flow sheet documentation for July 2018 indicated that the home currently uses a different version of the NPCR record than was used in November/December 2015. Interviews with PSWs #108, #109, RPNs #102, #104, and the DOC confirmed that the identified type of care is currently recorded under the personal hygiene section of the NPCR flow sheet.

A review of resident #001's activities of daily living (ADL) assistance care plan, last updated on an identified date in July 2018, indicated that one staff provides the identified resident care at the specified intervals. A review of resident #001's NPCR flow sheet documentation for July 2018, identified incomplete documentation for the provision of all care, including personal hygiene care, on five shifts in July 2018.

An interview with PSW #108 indicated that according to resident #001's plan of care the resident requires the identified care at the specified intervals, and that they perform the care for the resident two to three times on their identified shift. In interviews, PSW #108 and RPN #102 stated that the resident received the identified care daily at the specified intervals, but sometimes the staff were busy and forgot to document. RPN #102 indicated further that all documentation was missing on the flow sheet from the identified dates and that they knew there was no way that care had not been provided to the resident at all on the identified shifts. PSWs #108, #109, RPNs #102 and #104 confirmed that as per the home's policy, staff are required to document the provision of all care, including personal hygiene care which includes the identified care task, on all shifts.

During the course of the inspection, the Inspector made observations of resident #001 on multiple occasions and noted a variety of identified care supplies in the resident's bed room and bath room. The resident always appeared clean and well groomed. [s. 6. (9) 1.]

2. A review of resident #001's continence care plan, last updated on an identified date in June 2018, indicated the resident's continence status, products, and level of staff assistance required to meet the resident's continence care needs as per an outlined schedule and as needed.

A review of resident #001's NPCR flow sheet documentation for July 2018, identified incomplete documentation for the provision of all care, including continence care, on five shifts in July 2018.

An interview with PSW #108 indicated that according to resident #001's plan of care the

resident's continence status and level of assistance required for care are outlined for staff. The identified care is provided a minimum of twice on their shift. In interviews, PSW #108 and RPN #102 stated that the resident received the identified care daily, but sometimes the staff were busy and forgot to document. RPN #102 indicated further that all documentation was missing on the flow sheet from those dates, and they knew that there was no way that care had not been provided to the resident at all on the identified shifts. PSWs #108, #109, RPNs #102 and #104 confirmed that as per the home’s policy, staff are required to document the provision of all care, including continence care, on all shifts.

During the course of the inspection, the Inspector made observations of resident #001 on multiple occasions and noted the resident always appeared clean and well groomed. [s. 6. (9) 1.]

3. Resident #002's records were reviewed as a result of expanding the resident sample.

A review of resident #002’s activities of daily living (ADL) assistance care plan, last updated on an identified date in July 2018, indicated the resident requires a specific level of assistance for an identified personal care task, and a specific level of assistance for continence care. A review of resident #002’s NPCR flow sheet documentation for July 2018, identified incomplete documentation for the provision of all care, including personal hygiene care and continence care, on two identified shifts.

In interviews, PSW #109 and RPN #102 stated that the resident received the identified personal care and continence care daily, and that sometimes the staff were busy and forgot to document. RPN #102 indicated further that all documentation was missing on the flow sheet from those dates, and that they worked an identified shift on one of the identified dates in July 2018, and knew care had been provided to the resident as per their plan of care. [s. 6. (9) 1.]

4. Resident #003's records were reviewed as a result of expanding the resident sample.

A review of resident #003’s activities of daily living (ADL) assistance care plan, last updated on an identified date in July 2018, indicated the resident requires a specific level of assistance for an identified personal care task, and a specific level of assistance for continence care. A review of resident #003’s NPCR flow sheet documentation for July 2018, identified incomplete documentation for the provision of all care, including personal hygiene care and continence care, on one identified shift.

In interviews, PSW #109 and RPN #102, stated that the resident requires a specific level of assistance for personal care and continence care, and that sometimes the staff were busy and forgot to document. RPN #102 indicated further that there was no documentation on the flow sheet from the identified date and shift, which appeared to be missed documentation.

PSWs #108, #109, RPNs #102 and #104 confirmed that as per the home's policy, staff are required to document the provision of care for all residents on all shifts, including personal hygiene care and continence care.

During an interview, the DOC confirmed that the issue was one of missed documentation, that all care provided to all residents should be documented, and that staff were required to complete the identified personal care documentation on each date under all three areas of the specific section on the previous NPCR record, and under the personal hygiene section of the current NPCR record. [s. 6. (9) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following is documented: the provision of the care set out in the plan of care, to be implemented voluntarily.

Issued on this 6th day of September, 2018

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.