Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 11, 2020	2020_769646_0004	021855-19, 022678-19, 024419-19	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 365 Bloor Street East, 15th Floor TORONTO ON M4W 3L4

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

IVY LAM (646)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 30 and 31; and February 3, 4, and 5, 2019.

The following Critical Incident System (CIS) intakes were inspected during this inspection:
Log #021855-19 (M586-000038-19), Log #022678-19 (M586-000039-19), and Log #024419-19 (M586-000042-19) -- related to falls prevention and management,
Log #021855-19 (M586-000038-19) -- related to allegations of abuse, and
Log #021855-19 (M586-000038-19) -- related to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the acting Director of Care (DOC), clinical and operational Nurse Managers (NM), Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Physiotherapists (PT), Personal Support Workers (PSWs), and residents.

During the course of the inspection, the inspector conducted observations of staff and resident interactions and the provision of care, and reviewed resident health records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
4 WN(s)
2 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	Légende 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. 3. Residents’ Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident’s individuality and respects the resident’s dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity was fully respected and promoted.

This inspection was initiated related to a Critical Incident System (CIS) report submitted to the Ministry of Long-Term Care (MLTC) related to an incident where resident #001 had a witnessed fall and sustained an identified injury. Per resident, the fall was related to a physical altercation with a Personal Care Worker (PSW).

Review of the home's investigation notes and interview with resident #001 stated that prior to the fall incident, PSW #112 had shut the door in their face, and the resident had asked the PSW why they had shut the door in their face, and called the PSW a derogatory term. Resident #001 stated they had heard the PSW respond to the resident using the same derogatory term.

Interview with PSW #112, stated that prior to the fall incident, they had provided care for resident #001's roommate, and they proceeded to close the room's door as the PSW saw that resident #001 was not fully dressed. Resident #001 had called PSW #112 using the identified derogatory term twice, and PSW #112 had said, "It takes one to know one," in response once they were outside the room. PSW #112 further stated they did not think resident #001 had heard them. The PSW stated they had not used the identified derogatory term with resident #001. The PSW stated that they proceeded to take resident #001's roommate to the dining room for an identified meal. PSW #112 further stated that this was not the appropriate response in speaking with the resident, and this was not treating the resident with respect. The PSW stated that in the future, they would respond to the resident to let them know it was not appropriate to call the PSW by that term.

Interview with the Acting Director of Care (DOC) stated that it is the home's expectation for staff to treat residents with respect, and PSW #112 did not do so in this incident. [s. 3. (1) 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 rights of residents are fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #2: 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. (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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Review of resident #001's plan of care prior to the identified fall incident showed that the resident had identified responsive behaviours, and identified interventions for the PSWs and registered staff to address the resident's behaviours were included in resident #001's care plan.

Review of the progress notes and home's investigation notes showed that prior to the fall incident, resident #001 and PSW #112 had the identified verbal altercation, as identified in the finding under WN #1. The earlier interaction was not reported to RN #113 prior to the start of the identified meal.

Review of the home's investigation and risk management notes, and separate interviews with resident #001 and PSW #112, stated resident #001 had come into the dining room, where the PSW was serving beverages to residents at another table. Resident #001 asked PSW #112 for a beverage, and the PSW did not respond. Resident #001 continued to ask PSW #112 for the beverage, this time referring to the PSW with a

derogatory term. The PSW did not respond to the resident but continued to serve residents at the table beside the resident. Resident #001 was seen to get up to get the beverage container on their own, served themselves and sat down. PSW #111 went to the resident's table to retrieve the beverage container to the kitchen. PSW #112 stated at this point, resident #001 pushed their mobility device toward PSW #112, and PSW #112 called out to Registered Nurse (RN) #113's name for assistance, but the RN #113 stated they were busy. PSW #112 stated resident #001 pushed the mobility device towards them a second time, and the PSW had used one hand to hold on to the mobility device to avoid it bumping into the PSW again, as the PSW was holding onto a beverage container with the other hand and did not want it to spill. The PSW stated as they did so, resident #001 fell. PSW #112 further stated that they had not pushed resident #001's mobility device.

Interview with PSW #111 stated they had witnessed the incident with resident #001's mobility device and had seen the resident push the device toward PSW #112, and PSW #112 had tried to get RN #113's attention, but the RN continued to provide an identified care to a co-resident and did not come to their assistance. PSW #111 further stated the resident sat down forcefully at this point and fell.

Interview with RN #113 stated that resident #001 appeared upset when they came to the dining room and the staff had asked the resident if they were okay, to which the resident responded they were not okay because PSW #112 had slammed the door in their face earlier. RN #113 stated PSW #112 had called RN #113's name at this point, but the RN told the PSW that they would speak with the PSW after the meal. Later in the meal, RN #113 stated PSW #112 had called their name again, and the RN stated they would speak to the PSW later. PSW #112 called their name again, and the RN saw the PSW pull resident #001's mobility device and resident #001 pulling the device back, and resident #001 fell.

Interview with the acting DOC stated that review of the video footage could not show the area of the incident but could see that PSW #111 had clear view of the incident.

The acting DOC further stated it was the home's expectation for staff to follow the resident's care plan. The acting DOC stated resident #001 had asked the PSW for the beverage twice and it was expected of PSW #112 to respond to resident #001 in a calm manner if they could not immediately provide the beverage to the resident, or ask PSW #111 to serve resident when they were not able to, but the PSW did not respond to the resident and did not provide the planned intervention in addressing resident #001's

responsive behaviour. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident’s money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

During the inspection, interview with resident #001 stated that they had reported an incident to the previous DOC where PSW #114 had called the resident identified derogatory terms. The resident said the DOC had followed up with the resident after the incident, and had transferred PSW #114 to another floor, and the PSW had not worked with resident #001 since.

Interview with the acting DOC stated that the incident had come forward at an identified time when PSW #114 had complained to the previous DOC regarding resident #001's exhibited identified behaviours towards the PSW. During the home's interview with resident #001, resident #001 had brought forward that PSW #114 had called the resident a derogatory term. However, the resident was unable to state when, where and the context of this incident. Further, the resident had not reported this to the home prior to the PSW's complaint of resident #001. The acting DOC stated that the home's investigation was not able to substantiate the allegation of abuse, and there was no evidence that the incident had occurred. PSW #114 was not available to be interviewed at the time of the inspection.

The acting DOC further stated that when there is suspicion of alleged abuse of a resident, it is the home's expectation to immediately report the suspicion and the information upon which it was based to the Director, and this was not done related to the abovementioned incident for resident #001. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen, the resident was assessed and a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Review of the home's falls prevention policy, titled Falls Prevention and Management policy, showed after each fall, the care team was to identify root causes for the fall by completing the Post Fall Assessment Huddle.

Review of the assessments completed on the day of resident #001's fall on an identified date showed the resident had a head injury routine completed, but the post fall huddle was not done for the resident on this fall.

Review of the home's risk management for resident #001 on the identified date showed that RN #113 had completed the risk management as alleged abuse.

In an interview, RN #113 stated that after a resident has a fall, the assessments done for the resident include the post fall huddle, head injury routine as needed, and the head to toe assessment, and these assessments would be triggered by the risk management for falls. The RN further stated the clinically appropriate instrument to use would be the post fall huddle. The RN stated whatever assessment they had done would be documented on PointClickCare.

Separate interviews with Nurse Manager (NM) #106, who is the home's Falls Lead, and another interview with the acting DOC, stated that RN #113 may have missed the post fall huddle, as they had not selected the Fall option on risk management, and PCC had not prompted the RN to complete the post fall huddle assessment.

The acting DOC stated it is the home's expectation for staff to complete the post fall huddle after each fall, as this is the clinical assessment tool specifically designed for falls, and it was not done for resident #001's fall the identified date. [s. 49. (2)]

Issued on this 12th day of February, 2020

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

Original report signed by the inspector.