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
Aug 11, 2020	2020_751649_0014	003485-20, 009783-20, 013869-20	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

JULIEANN HING (649)

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): July 17, 20, 22, and 23, 2020.

The following intakes were completed in this critical incident system (CIS) inspection:
Logs #013869-20 and #003485-20 related to falls prevention and management.
Log #009783-20 related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the clinical nurse manager (CNM), nurse manager (NM), registered nurse (RN), registered practical nurses (RPNs), personal support workers (PSWs), and residents.

During the course of the inspection the inspector reviewed residents' health records, staffing schedules, conducted observations related to the home's care processes, and reviewed 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

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	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 every resident has the right to be treated with courtesy and respect and in a way that fully recognizes resident #002's individuality and respects the resident's dignity.

A critical incident system (CIS) report was submitted to the Ministry of Long-Term Care (MLTC), related to an allegation of staff to resident abuse.

According to the CIS report, resident #002 alleged that PSW #103 had shoved food into their mouth when they opened their mouth to speak, and during their personal hygiene care had been rough with them, and failed to wash them properly.

In an interview with the resident, they alleged that they had not been properly washed by PSW #103, and told the inspector that it was not the first time. The resident further explained that PSW #103 had shoved food into their mouth and told the the resident that they only had 10 minutes to feed them because they had to go on their break. According to the resident, they told PSW #103 to slow down but they had their own way of doing things and eventually did not bother. The resident expressed to the inspector that they felt they were treated worse than an animal. The resident further expressed that PSW #103 had been rough when turning them in bed causing discomfort. According to the resident they had told PSW #103 about this but after a while did not bother as there was no response from PSW #103. The resident could not recall PSW #103 being rough with them during personal hygiene care.

In an interview with PSW #103 they denied the above mentioned allegations, and stated that resident #002 had never mentioned any of these concerns to them.

In an interview with RPN #102, they told the inspector that they were asked by PSW #101 to change resident #002's dressing, and thought it was odd since it was not scheduled to be changed. Upon further inquiry with the resident they told them that they did not want the dressing changed because they were not washed properly, and thought what's the use. According to the RPN the resident told them that they enjoyed when they and PSW #101 fed them. The RPN further stated that the resident told them that when PSW #103 fed them they told the resident that they had only 10 minutes, and also that the PSW had been aggressive towards them during care. RPN #102 told the inspector that resident #002 started to become teary eyed and did not want to say more as they were concerned of retaliation from the alleged PSW.

A review of the home's investigation notes indicated that PSW #103 had received disciplinary action related to the concerns expressed by the resident, and had since been removed from their care assignment.

In an interview with nurse manager (NM) #108, they acknowledged that PSW #103's actions on the above mentioned date were unacceptable and constituted failure to treat resident #002 with dignity and respect.

Resident #002 had not been treated with courtesy and respect in a way that fully recognizes their individuality and respects their dignity when PSW #103 had provided care to them on the above mentioned date. [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 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.

Issued on this 11th day of August, 2020

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

Original report signed by the inspector.