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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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 13, 2021 | 2020_631210_0019 | 015421-20, 016938-20, 023201-20 | Complaint |

### 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

SLAVICA VUCKO (210)

## 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): December 16, 17, 18, 21, 22, 23, 24, 29, 31, 2020 and January 4, 2021.**

**During the course of the inspection the following complaints were inspected:**
**-Intake #016938-20, related to personal support services, infection prevention and control, continence care, skin and wound care;**
**-Intake #023201-20, related to falls prevention and management, safe and secure home.**

**This inspection was conducted concurrently with Critical Incident System (CIS) report**
**-Intake #015421-20 related to allegations of abuse and neglect.**

**During the course of the inspection, the inspector(s) spoke with the acting Executive Director (ED), interim Director of Care (DOC), Nurse Manager (NM), Acting Manager of Resident Services (MRS), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Registered Dietician (RD), Nutrition Manager (NM), Physiotherapist (PT), and Personal Support Workers (PSWs).**

**During the course of the inspection the inspector observed the provision of care, reviewed the clinical records and interviewed residents' family members.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Falls Prevention**
**Nutrition and Hydration**
**Personal Support Services**
**Reporting and Complaints**
**Safe and Secure Home**
**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**

- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| **NON-COMPLIANCE / NON - RESPECT DES EXIGENCES** | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.**

**Findings/Faits saillants :**

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

On an identified date and time, a resident fell on the floor, while being transported by staff in their wheelchair. The resident sustained an injury.

The resident was using a wheelchair for transportation and was not able to self propel. The expectation was that staff applied foot rests on the resident's wheelchair when they were transported from one location to another as they were not able to self-propel. The resident was not wearing proper footwear. When the resident was transported by staff, the resident fell from the wheelchair onto the floor. A post fall assessment was performed, indicating the resident was wearing improper footwear and the foot rests were not applied onto the wheelchair.

A resident was not safely transported in their wheelchair on an identified date and sustained a fall.

Sources: interview with the resident's family member, review of the clinical record, observations of provision of care, interview with registered nurses and other staff. [s. 5.]

***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 home is a safe and secure environment for its residents, to be implemented voluntarily.***

**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints**

**Specifically failed to comply with the following:**

**s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the licensee immediately forwarded any written complaints that had been received concerning the care of a resident or the operation of the home to the Director.

On an identified date, a resident had a fall, while being transported. A family member of the resident sent an email to the home the same day of the incident inquiring about the incident, and safety of the resident. The home investigated the incident and responded to the family member within 10 days.

The home did not forward a copy of the written complaint from the resident's family member to the Director. [s. 22. (1)]

**Issued on this 25th day of January, 2021**

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

**Original report signed by the inspector.**