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
Jun 4, 2021	2021_766500_0015	014991-20, 017752-20, 017766-20, 019242-20, 021429-20, 003457-21, 005711-21, 007270-21	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
Seniors Services and Long-Term Care (Union Station) c/o 55 John Street 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

NITAL SHETH (500)

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): May 18, 19, 20, 21, 24, 25, 26, 27, and 31, 2021.

The following intakes were completed during this inspection:

-Logs #017752-20 (M586-000016-20), #005711-21 (M586-000006-21), and #007270-21 (M586-000007-21), #017766-20 (M586-000017-20), and #019242-20 (M586-000019-20) related to falls resulting in injury
-Logs #014991-20 (M586-000013-20) and #021429-20 (M586-000020-20) related to duty to protect
-Log #003457-21 (M586-000001-21), related to unexpected death of a resident

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (DOC), Nurse Managers, Registered Nursing Staff, Personal Support Workers and Residents.

During the course of inspection, the inspectors observed the residents' care areas; and reviewed the residents' and the home's records.

Inspector Rodolfo Ramon (#704757) attended this inspection during orientation.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 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 O.Reg 79/10, s. 112. Prohibited devices that limit movement
For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Findings/Faits saillants :

1. The licensee has failed to ensure that prohibited devices that limit movement were not used in the home: sheets, wraps, tensors, or other types of strips or bandages used other than for a therapeutic purpose.

A Critical Incident System (CIS) report was submitted to the Ministry of Long-term Care (MLTC) related to duty to protect. On an identified day, unit staff discovered a resident restrained with a prohibited device, limiting the resident's movement.

Progress note indicated that a Personal Support Worker (PSW) called a Registered Practical Nurse (RPN) to report that a resident was restrained with a prohibited device, limiting the resident's movement and putting the resident at risk. Upon assessment, the resident was observed with an injury.

PSW #115 and Nurse Manager (NM) #116 verified that the staff are not allowed to restraint the residents unless it is ordered by the physician. They confirmed the restraint used with the resident was a prohibited device and should not have been used.

Sources: CIS, Progress note, Interviews with PSW #115, NM #116. [s. 112.]

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 prohibited devices that limit movement are not used in the home such as sheets, wraps, tensors, or other types of strips or bandages used other than for a therapeutic purpose., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was administered to a resident in the home unless the drug has been prescribed for the resident.

A CIS report was submitted to the MLTC for the unexpected death of a resident.

On an identified day, a PSW went into a resident's room for a regular check. The PSW observed the resident with a change in their level of consciousness. The resident's SDM was still assisting the resident and provided with a specified medication to the resident, which was not prescribed in the home. The PSW asked the SDM to stop.

Interview with RPN #105 verified that the SDM provided an identified medication to the resident, which was not prescribed for the resident. The home has a policy that the residents' are administered only prescribed medications, and the family is required to inform the staff in the home before providing any kind of medication to the resident which are not prescribed in the home.

Interview with NM #102 verified that family cannot provide any medication to the resident without informing the registered staff in the home.

Sources: CIS, Progress note, Interviews with RPN #105, NM #102 and others. [s. 131. (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 no drug is administered to a resident in the home unless the drug has been prescribed for the resident., to be implemented voluntarily.

Issued on this 7th day of June, 2021

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

Original report signed by the inspector.