Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: February 13, 2024

Inspection Number: 2024-1590-0001

Inspection Type:
Critical Incident

Licensee: City of Toronto

Long Term Care Home and City: True Davidson Acres, Toronto

Lead Inspector	**Inspector Digital Signature**
Irish Abecia (000710)	Irish J Abecia Digitally signed by Irish J Abecia Date: 2024.02.22 16:17:29 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 5-9, 2024

The following intakes were inspected in this Critical Incident (CI) inspection:

- Intake: #00104499 [CI: M586-000034-23] - Was related to a disease outbreak
- Intake: #00106372 [CI: M586-000001-24] - Was related to a fall

The following intakes were completed in this CI inspection:

- Intake: #00100164 [CI: M586-000026-23] - Was related to a disease outbreak
- Intake: #00102246 [CI: M586-000033-23] - Was related to a fall

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Maintenance services

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (b)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

The licensee failed to ensure that procedures were implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home were kept in good repair.

Rationale and Summary
A resident had a fall on an identified date. At the time of the fall, the resident required equipment to be used as an intervention to mitigate their risk of falls.

A Registered Practical Nurse (RPN) identified that the equipment was not working prior to resident's fall, and they had notified the clinical lead for a replacement. The

resident did not receive replacement equipment that was in good state of repair prior to the fall. A Registered Nurse (RN) verified that the equipment was not applied and was not working at the time of the fall. Another clinical lead indicated they replaced the equipment the day after the fall incident.

Failure to ensure that equipment in the home was kept in good repair led to the staff's inability to promptly respond to the resident prior to falling.

Sources: A resident's clinical records; interviews with an RN and other staff.

[000710]