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

Original Public Report

Report Issue Date: March 14, 2024
Inspection Number: 2024-1590-0002
Inspection Type: Proactive Compliance Inspection
Licensee: City of Toronto
Long Term Care Home and City: True Davidson Acres, Toronto

Lead Inspector	**Inspector Digital Signature**
Susan Semeredy (501)	Susan L Semeredy Digitally signed by Susan L Semeredy Date: 2024.05.16 13:20:27 -04'00'

Additional Inspector(s)
Cindy Ma (000711)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 23, 25, 26, 29, 30, 2024 and May 1, 3, 6, 7, 2024

The following intake(s) were inspected:

- Intake: #00114191 - Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Residents' and Family Councils

Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure a resident was protected from abuse and neglect by a Personal Support Worker (PSW).

Rationale and Summary
Section 2 of the Ontario Regulation 246/22 defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident."

Section 7 of the Ontario Regulation 246/22 defines neglect as "the failure to provide a resident with the treatment care, services or assistance required for health, safety or well being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

It was reported to the inspector that a PSW who provided care to a resident had verbal communication with them that made them feel degraded. As well, the PSW failed to provide care at times. The resident had reported this and the home took action, but the resident was still fearful of reprisal.

During the home's investigation into the matter, the resident indicated the PSW neglected them and made comments that made them feel unworthy. Following these allegations, a Nurse Manger (NM) took action and after meeting with the PSW determined the PSW failed to provide care to a resident.

Failing to protect a resident from neglect and abuse risked diminishing their health and sense of well-being.

Sources: The home's investigation notes, interviews with a resident, and staff. [501]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The licensee failed to report an allegation and suspicion of neglect and abuse by a PSW towards a resident.

Rationale and Summary
A resident reported to a PSW how upset they were by the encounters they were having with another PSW. The PSW reported this to a Nurse Manager (NM). It was documented that the resident told the NM that when they asked for care to be provided, the PSW made statements that degraded them and at times this PSW did not provide care. In response, the NM took action and had a meeting with the identified PSW. It was identified in a discipline letter that the PSW failed to provide care to the resident.

The Administrator acknowledged the home had sufficient grounds to suspect that a resident was neglected and abused by a PSW and should have reported this to the Director.

Failing to report this allegation put a resident at risk for continued anxiety and fear.

Sources: The home's investigation notes, interviews with a resident, a NM and other staff. [501]

WRITTEN NOTIFICATION: Doors in a home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors

leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,

The licensee failed to ensure that all doors leading out to the terraces were kept locked when unsupervised.

Rationale and Summary
Observations conducted during the inspection showed the doors leading out to the terraces on two floors were unlocked when not supervised by staff.

Two RPNs, a Recreation Service Assistant and a Nurse Manager stated that doors leading out to the terraces should have been locked when not supervised by staff.

Failing to ensure that doors were kept locked when unsupervised posed a risk to the safety of residents.

Sources: Observations and interviews with staff. [000711]

WRITTEN NOTIFICATION: Menu Planning

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (4) (a)
Menu planning
s. 77 (4) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;

The licensee has failed to ensure that a resident was offered three meals daily.

Rationale and Summary

A resident was not in the dining room for a meal. An RPN indicated the resident was being monitored in their room for medical reasons. It was observed that the resident was in bed and had a previous meal tray that was half eaten in their room. The RPN indicated that they attempted to feed the resident their left-over meal which they refused and therefore was not offered the current meal.

The Registered Dietitian acknowledged that the resident should have been offered a fresh meal.

Failing to offer a resident a meal put them at risk for decreased nutritional status related to less-than-optimal intake.

Sources: Observation, a resident's plan of care and interviews with staff. [501]

WRITTEN NOTIFICATION: Food Production

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)
Food production
s. 78 (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 246/22, s. 78 (3).

The licensee has failed to ensure that all food in the food production system were served using methods to prevent food borne illness.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure there is a policy so that that all foods in the food production system are served using methods to prevent food borne illness, and that it is complied with.

Specifically, staff did not comply with the policy Meal Service Temperature Recording #FN-0313-01, published August 15, 2021, which stated that Food Service Workers (FSWs) are to take the temperature prior to serving for each menu item for all diet types. FSWs are to record temperatures to ensure food temperatures are acceptable (cold food 4 degrees Celsius/40 degrees Fahrenheit, hot food 60 degrees Celsius/140 degrees Fahrenheit or more). Cold food/beverages which are not cold enough should be cooled to appropriate temperatures before service and temperatures recorded.

Rationale and Summary
During a meal service, a FSW was observed to have documented the egg salad at 4 degrees Celsius. The FSW was then observed to have taken the temperature again and it was 6 degrees Celsius and appeared hesitant of how to proceed.

It was noted that all the cold desserts were documented at 4 degrees Celsius. When asked to take the temperature of two of the items which were being stored in the refrigerator, the fruit cocktail was 6.8 degrees Celsius, and the minced fruit cocktail was 4.8 degrees Celsius. The temperature logs for this dining area for several days documented all cold food was at 4 degrees Celsius or the temperature was not taken at all.

The Food and Nutrition Manager (FNM) acknowledged the FSW did not take the temperature of the cold food according to their policy as it would not be possible for all cold food to be consistently a certain temperature.

Failing to take the temperatures of food at the point of service put residents at risk for food borne illness.

Sources: Observation, food temperature logs, the home's policy and interviews with

a FSW and FNM. [501]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Specifically, IPAC Standard for Long-Term Care Homes, s. 9.1 (f) stated that the licensee shall ensure that Routine Practices and Additional Precautions were followed in the IPAC program. At minimum Additional Precautions shall include proper use of Personal Protective Equipment (PPE), including appropriate selection, application, removal, and disposal.

Rationale and Summary
An RPN was observed donning their PPE in the following order: protective eyewear, gown and gloves, prior to entering a resident's room who was on droplet and contact precautions. After the RPN finished providing care to the resident, they were observed doffing their PPE in the following order: gloves, hand hygiene, gown, removed face shield and performed hand hygiene.

The home's policy directed staff to put on PPE in the following order: perform hand hygiene, gown, mask/N95 respirator, protective eyewear and gloves. The policy

directed staff to take off PPE in the following order: gloves, gown, perform hand hygiene, protective eyewear, mask/N95 respirator, and hand hygiene.

Infection and Prevention Control (IPAC) Lead confirmed that the RPN did not don and doff PPE and complete hand hygiene in the appropriate order prior to entering and upon exiting the resident's room.

Sources: Observation, home's PPE policy (IC-0604-00, published 01-05-2015) and an interview with the IPAC Lead. [000711]

WRITTEN NOTIFICATION: Quality

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 10.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
10. One member of the home's Family Council, if any.

The licensee has failed to ensure the home's continuous quality improvement (CQI) committee included one member of the home's Family Council (FC).

Rationale and Summary

The FC President stated they were not aware of any members of the FC being part of the CQI committee. The minutes of the CQI meetings did not indicate there was a FC member present. The Administrator acknowledged that a FC was not a member of the committee and the FC assistant indicated they were not made aware of how to involve the FC members in the CQI committee.

Failure to include a FC member in the CQI committee may impact how the FC is able to voice their concerns about quality improvements within the home.

Sources: Minutes from the CQI meetings, email communication with the FC assistant and interviews with the FC President and the Administrator. [501]

WRITTEN NOTIFICATION: Quality

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. iii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure the CQI initiative report contained how, and the dates when, the results of the Resident and Family/Caregiver Experience Survey were communicated to the residents and their families and members of the staff of the home.

Rationale and Summary

The Administrator provided to the inspector the home's Quality Improvement Plan (QIP) Narrative dated March 27, 2024, the QIP Workplan 2024/25, True Davidson Acres Resident and Family Your Opinion Counts Survey 2023, and the QIP Progress Report on the 2023/24 QIP. The inspector also viewed on the home's website their preamble for the Quality Improvement Report. A statement regarding how, and the

dates when, the results of the Resident and Family/Caregiver Experience Survey (Your Opinion Counts) were communicated to the residents and their families and members of the staff of the home could not be found. The Administrator confirmed that this information was not present in their reports.

Sources: The home's CQI reports and an interview with the Administrator. [501]

WRITTEN NOTIFICATION: Additional training — direct care staff

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (2) 1.
Additional training — direct care staff
s. 261 (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 82 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 82 (7) of the Act.

The licensee has failed to ensure that all direct care staff received annual training on skin and wound care, falls prevention and management and pain management.

Rationale and Summary
(i) The 2023 skin and wound care annual training records were reviewed and it was noted that not all direct care staff completed their annual training as required.

Skin and Wound Prevention and Management Lead confirmed that all direct care staff were required to complete their annual training and did not in 2023.

Failure to ensure staff training is completed in the areas of skin and wound care posed a risk of staff not being aware of the prevention and management of skin and

wound.

Sources: 2023 training records; interviews with Skin and Wound Prevention and Management Lead. [000711]

Rationale and Summary
(ii) The 2023 falls prevention and management annual training records were reviewed and it was noted that not all direct care staff completed their annual training as required.

Falls Prevention and Management Lead confirmed that all direct care staff were required to complete their annual training and did not in 2023.

Failure to ensure staff training is completed in the areas of falls prevention and management posed a risk of staff not being aware of the prevention and management of falls.

Sources: 2023 training records; interviews with Falls Prevention and Management Lead. [000711]

Rationale and Summary
(iii) The 2023 pain management annual training records were reviewed and it was noted that not all direct care staff completed their annual training as required.

Pain Management Lead confirmed that all direct care staff were required to complete their annual training and did not in 2023.

Failure to ensure staff training is completed in the areas of pain management posed a risk of staff not being aware of the prevention and management of pain.

Sources: 2023 training records; interview with Pain Management Lead. [000711]