Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 22, 2018	2018_644507_0022	009851-17, 016548-17, 025278-17	Critical Incident System

Licensee/Titulaire de permis

Downsview Long Term Care Centre Limited
3595 Keele Street NORTH YORK ON M3J 1M7

Long-Term Care Home/Foyer de soins de longue durée

Downsview Long Term Care Centre
3595 Keele Street NORTH YORK ON M3J 1M7

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

STELLA NG (507)

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): October 23, 24, 25, 29, 30 and 31, November 1 and 2, 2018.

The following critical incident reports were inspected concurrently with this inspection:
#00985-17 (CIS #1041-000006-17), #016548-17 (CIS #1041-000008-17) and #025278-17 (CIS #1041-000013-17) were related to alleged resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Social Worker (SW), Physiotherapy Assistant (PTA) and residents.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The Licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Review of an identified Critical Incident System report (CIS) submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date and the progress notes of residents #001 and #002 indicated that on the above mentioned identified date, an identified staff observed resident #001 exhibit responsive behaviours towards resident #002 in resident #002's room.

Review of the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) completed approximately two months prior for resident #002 indicated that the resident was dependent for all activities of daily living (ADL).

Review of the written plan of care completed two months prior to the above mentioned incident for resident #001 indicated that the resident was identified having potential for responsive behaviours. The same written plan of care also identified resident #001 had exhibited responsive behaviours towards resident #002 one month prior to the completion of the written plan of care.

Review of the progress notes for residents #001 and #002 indicated that approximately three months prior to the above mentioned incident, resident #001 was observed exhibiting responsive behaviours towards resident #002. Staff intervened and placed resident #001 on specific interventions.

Review of the progress notes for residents #001 and #002 indicated that on the identified date when the CIS was submitted to the MOHLTC, resident #001 was observed exhibiting responsive behaviours towards resident #002. Staff intervened and placed resident #001 on the above mentioned specific interventions.

Further review of the progress notes for residents #001 and #002 indicated that three days after the above mentioned incident, resident #001 was observed exhibiting responsive behaviours towards resident #002.

Residents #001 and #002 were not interviewable.

In an interview, staff #103 stated that the home should have implemented interventions after the incident which was submitted to the MOHLTC on the above mentioned identified date to minimize the risk and potentially harmful interactions between residents #001 and #002. [s. 55. (a)]

Issued on this 26th day of November, 2018

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

Original report signed by the inspector.