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

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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
May 1, 2019	2019_654618_0016	002802-19, 003427-19	Complaint

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

CECILIA FULTON (618)

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): April 23, 24, 25, 2019.

The following complaint intake logs were inspected during this inspection:
002802-19 - related to plan of care.
003427-19 - related to change in condition.

During the course of the inspection, the inspector(s) spoke with The Assistant Director of Care (ADOC), Registered Staff (RN/RPN), Personal Support Workers (PSW), Residents and Resident's substitute decision makers (SDM).

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

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The Licensee has failed to ensure care set out in the plan of care was provided to the resident as specified in the plan.

A complaint was received by the Ministry of Health and Long-term Care (MOHLTC), with concerns that resident #002 may not have been receiving baths/showers as scheduled or receiving required oral care.

An interview with the complainant identified that they had concerns that resident #002 was not being bathed regularly. The complainant further revealed that they thought the resident received showers on their designated bath days and bed baths as needed on other days.

Review of resident #002's plan of care identified that they were to receive bathing by shower on identified week days.

Interview with PSW #101 and #102, both of whom are members of the shower team who provide resident #002's bath care, revealed that resident #002 received a bed bath. PSW #101 could not recall if a shower had ever been provided to the resident, and PSW #102 stated that since moving to the unit, the resident had never received anything other than a bed bath because of resident's abilities.

Resident #002's plan of care was reviewed with the Assistant Director of Care (ADOC), and they confirmed that the resident received bed baths only. The ADOC also confirmed that the plan of care as written does not provide clear direction to the staff, and the interventions as written were not being provided to resident #002.

Resident #002's plan of care also included interventions for the provision of mouth care including for staff to provide total assistance every morning and bedtime, and to swab mouth with mouth wash.

In an interview with day shift PSW #103, they stated that they provided resident mouth care every morning by swabbing the resident's mouth with a pre-moistened, lemon swab. PSW #103 stated they did not use mouth wash when providing mouth care.

Review of the plan of care conducted with the ADOC identified that the plan as written is the expectation, and the information provided by the staff would not be consistent with what the plan of care provides. [s. 6. (7)]

2. The licensee has failed to ensure that the following were documented: the provision of the care set out in the plan of care.

Interview with PSW #101 and #102, who are members of the shower team both stated that resident #002 received bathing by bed bath on identified week days.

Review of resident #002's observation/flow sheet monitoring form for April 2019, revealed that the care was not documented as having been provided on four occasions.

Interview with PSW #101 and #102, identified that they do not do the documentation. The documentation of care on this form is performed by the resident's primary PSW.

Interview and review of the sheet with PSW #103 confirmed the missing entries.

As a result of non-compliance related to resident #002, a review of the observation/flow sheet monitoring was conducted for resident's #003 and #004, and both flow sheets revealed documentation of provision of care was missing on several occasions in April 2019.

Interview and review of the flow sheets with the ADOC confirmed the missing documentation. [s. 6. (9)]

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 all written complaints concerning the care of a resident or the operation of the long-term care home were immediately forwarded to the Director.

A complaint was received by the Ministry of Health and Long-term Care (MOHLTC).

In an interview conducted on April 16, 2019, the complainant informed the Inspector that they had sent the home a written complaint also.

An interview with the ADOC confirmed that the home had received a complaint via e-mail on and identified date, from the SDM of resident #002, expressing concerns regarding the care of the resident and that the home had not forwarded that written complaint to the Ministry. [s. 22. (1)]

Issued on this 1st day of May, 2019

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

Original report signed by the inspector.