Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Nov 7, 2019	2019_493652_0016	014026-19	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

NATALIE MOLIN (652)

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): July 22, 23, 24, October 8 and 17, 2019. Off Site: October 7, 2019

The following complaint inspection was conducted:

Log #014026-19 related to Responsive Behaviours.

During the course of the inspection, the inspector(s) spoke with the associate director of care (ADOC), registered nursing staff, personal support workers (PSWs), behaviour support lead (BSO).

During the course of the inspection, the inspector(s) conducted a tour of the home; observed staff to resident interactions and the provision of care, conducted record review.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Substitute Decision Maker (SDM), if any, and the designate of the resident / SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.

Record review of a video recording submitted to the Ministry of Long-Term Care (MLTC) by resident #001's SDM, indicated resident #001 was assisted by the Emergency Medical Services (EMS) and the police during resident #001's transfer from the home to the hospital. This video recording showed resident #001 calm and responsive during the preparation to be transferred.

Record review of resident #001's progress notes on an identified dated indicated their SDM called the home approximately 10 minutes post transfer to hospital to ask why resident #001 was transferred to the hospital.

Record review of resident #001's physician orders on an identified date and time indicated resident #001 was transferred to Hospital.

Record review of the physician's notes on an identified date indicated they attempted to talk to resident #001's SDM about resident #001's behaviour which was unmanageable at the home and calls were terminated by the SDM. This note also indicated resident #001 demonstrated identified responsive behaviours and was transferred to hospital.

Record review of resident #001's progress notes for an identified period, indicated they had a history of responsive behaviours and in some instances it took four to five staff members to provide care to resident #001.

In an interview with resident #001's family member they indicated resident #001 was not demonstrating any responsive behaviours at the time of the transfer to hospital and the home did not contact them prior to sending resident #001 to the hospital, and if they did, they would have had the opportunity to take resident #001 home versus going to the hospital.

In an interview registered nurse (RN) #107 indicated resident #001 had responsive behaviours and the team could not manage resident #001 and provide care at all. The behaviours were still happening when resident #001 was transferred to hospital.

In an interview with Associate Director of Care (ADOC) #101 and Director of Care (DOC) #105 they indicated that resident #001 demonstrated responsive behaviours. DOC #105

indicated the home implemented an intervention to manage resident #001's responsive behaviours. The DOC also indicated the team held teleconferences with the SDM however, they always end the calls.

In an interview attending physician #106 indicated the goal of the transfer to hospital was to see if they could help the team figure it out or do anything for the resident related to their responsive behaviours. The attending physician also indicated they tried to speak with resident #001's SDM however, the SDM ended the calls but sent emails instead.

In an interview RPN #102 after reviewing the video recording related to resident #001's transfer to hospital, they indicated the SDM could have been notified prior to sending resident #001 to the hospital.

ADOC acknowledged resident #001's SDM could have been notified prior to transferring resident out.

There was no evidence to support the home contacted resident #001's SDM prior to implementing the transfer to hospital.

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 SDM, if any, and the designate of the resident / SDM been provided the opportunity to participate fully in the development and implementation of the plan of care, to be implemented voluntarily.

Issued on this 7th day of November, 2019

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

Original report signed by the inspector.