Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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
Aug 14, 2020	2020_816722_0013	011334-20	Critical Incident System

Licensee/Titulaire de permis

Gem Health Care Group Limited
15 Shoreham Lane, Suite 101 Halifax, NS UNKNOWN ON B3P 2R3

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

COREY GREEN (722), ADAM DICKEY (643)

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): July 27-31, and August 4, 2020.

The following intake was inspected during this Critical Incident System (CIS) inspection: Log #011334-20 related to a fall.

During the inspection, the inspector made observations in the home, and reviewed resident health records.

During the course of the inspection, the inspector(s) spoke with the Acting Director of Care (DOC), the Physiotherapist (PT) and Registered Practical Nurses (RPNs).

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **2 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #013 collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care related to the sudden or unexpected death of resident #013 on a specified date. The home first reported resident #013's death via the After Hours line, which indicated that the resident had fallen on a specified date and died the following day. Review of the CIS report showed that resident #013 had an unwitnessed fall with no apparent injuries noted on assessment.

Review of resident #013's progress notes in the electronic health record showed that the resident sustained a fall and was found on the floor. Resident #013 was assessed post fall by RPN #112, who indicated in the progress notes that a specified falls prevention intervention would be initiated.

Review of resident #013's care plan, under the falls focus, showed that the resident was at risk for falls with several falls interventions in place. The additional intervention specified by RPN #112 was not identified in resident #013's care plan under the falls focus.

In an interview, RPN #112 indicated that they had completed the assessment of resident #013 following their fall. In reviewing documentation, the RPN acknowledged that a new fall prevention intervention was to be added to the resident's care plan as specified in the progress note. RPN #112 indicated that when the specified intervention was to be added

to a resident’s plan of care, they would request the equipment from their nurse manager. RPN #112 indicated that when the fall occurred, the home was in a COVID-19 outbreak, and they did not recall if they had discussed the intervention with the nurse manager to implement or if the intervention was ever implemented.

In an interview, RPN #118 indicated that resident #013 had fall prevention interventions in place. They also indicated that they were not aware of any suggestion to implement the new fall prevention intervention specified by RPN #112.

In an interview, PT #120 indicated that they participated in the falls prevention and management program in the home by conducting assessments of residents after falls and working with the nursing department to develop and implement interventions for falls prevention and management. PT #120 indicated that they had not discussed the new specified fall prevention intervention with nursing staff, and acknowledged that resident #013 may have benefited from the intervention. PT #120 acknowledged that staff had not collaborated in the development and implementation of resident #013’s plan of care related to falls prevention.

In an interview, Acting DOC #103 indicated that fall prevention and management equipment is requested by registered staff from the Nurse Manager or Clinical Coordinator when required for a resident. DOC #103 indicated that they were the Clinical Coordinator responsible for the falls program at the time but they were not present in the home at the time of resident #013's fall. DOC #103 indicated the registered staff could have requested the required fall prevention equipment from PT #120 at the time of resident #013's fall, as much of the management team was ill and not able to work at the time. [s. 6. (4) (b)]

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 staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #016 had fallen, a post fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Resident #016 was reviewed to expand the resident sample due to identified noncompliance for resident #013 related to a fall. Review of the home's electronic health records showed that resident #016 sustained a fall on a specified date. Review of resident #016's progress notes did not show a completed post fall assessment for the identified fall.

In an interview, RPN #119 indicated that each time a resident has a fall, a post fall assessment would be completed using a structured progress note titled 'Fall (Downsview Format)' in the electronic health record. RPN #119 indicated that they were on duty at the time of resident #016's fall and had conducted a physical assessment of the resident, but did not recall completing a post fall assessment using the structured progress note.

In an interview, Acting DOC #103 indicated that it was the expectation of the home for registered staff to complete a post fall assessment following each resident fall incident using the 'Fall (Downsview Format)' structured progress note in the electronic health record. DOC #103 acknowledged that a post fall assessment using a clinically appropriate tool was not completed for resident #016's fall. [s. 49. (2)]

Issued on this 18th day of August, 2020

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

Original report signed by the inspector.