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
Mar 17, 2022	2022_766500_0007	017091-20, 017243-20, 017753-20, 018614-20, 006746-21, 010172-21, 010856-21, 010915-21, 013024-21, 013894-21, 014465-21, 015695-21, 016815-21, 018841-21, 019068-21, 020149-21	Critical Incident System

Licensee/Titulaire de permis

Gem Health Care Group Limited
15 Shoreham Lane, Suite 101 Halifax NS 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

NITAL SHETH (500), MATTHEW CHIU (565)

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): February 22, 28, March 1-4 and 7, 2022.

There were 12 intakes related to falls resulting in injury, three intakes related to duty to protect, and one intake related to injury with unknown cause completed during this Critical Incident System (CIS) inspection.

The non-compliance issued under s. 6 (7) for resident #002 was identified during concurrent inspection #2022_650565_0006.

During the course of the inspection, the inspector(s) spoke with The Administrator, the Director of Care (DOC), Nurse Practitioner (NP), Registered Dietitian (RD), Infection Prevention and Control (IPAC) Lead, Behavioral Support Ontario (BSO) Lead, Clinical Coordinators, Registered Nursing Staff, Personal Support Workers (PSWs), and Housekeeping Staff.

During the course of inspection, the inspectors observed residents' care areas, reviewed residents' and the home's records, and reviewed IPAC practices in the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
3 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #002, #014, and #016 as specified in the plan.

A Personal Support Worker (PSW) left resident #014 unattended during personal care to call the nurse. The resident was identified with pain and injury upon their return. The resident stated they fell, and had an injury. The resident was transferred to the hospital.

As per the resident’s plan of care, the resident was at risk for fall and the staff were to monitor the resident for safety. As per the resident’s plan of care, the PSW should not have left the resident unattended and should have provided one person assistance during care.

Sources: Resident #014’s care plan, CIS, interviews with PSW, RPN, and the DOC. [s. 6. (7)]

2. An RPN observed an inappropriate interaction between resident #016 and resident #018. The RPN immediately asked resident #016 to move away from resident #018; but they refused.

Resident #016’s care plan stated that the resident was to receive 1:1 supervision due to responsive behaviours. According to RPN #119, the resident did not receive 1:1 supervision at the time of the incident as per their plan of care.

Sources: Resident #016’s care plan, CIS, interviews with a PSW, RPN, BSO Lead and the DOC. [s. 6. (7)]

3. Resident #002 was at nutritional risk and had significant weight changes documented. The Registered Dietitian (RD) initiated a nutritional supplement for the resident however the resident was not provided with the supplement set out in their plan of care because the order was not transcribed.

Sources: Review of the resident’s dietitian referral, progress notes, orders, medication administration record; interviews with RPN, the DOC and other staff. [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to protect resident #017 from resident #016 and resident #012 from resident #011'abuse.

Section 2 (1) of the Ontario Regulation 79/10 defines sexual abuse as "Any non-consensual touching, behaviour or remark of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

An Activity Aide observed resident #016 with sexually inappropriate behaviour towards resident #017. The Activity Aide heard resident #017 raise their voice saying "No, No",. Resident #017 appeared uncomfortable.

Sources: CIS, interviews with a PSW, RPN, BSO lead, and the DOC. [s. 19. (1)]

2. Section 2 (1) of the Ontario Regulation 79/10 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident."

Resident #011 had physical altercation with resident #012. Resident #012 sustained an injury and pain, and was sent to the hospital.

Sources: CIS , interviews with a PSW, RPN, BSO lead, and the DOC.

These issues were additional evidence to support Compliance Order (CO) #002, issued under s. 19 (1) during inspection #2021_526645_0011, and occurred prior to the compliance due date November 30, 2021. [s. 19. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure, that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

The evaluation of the home's policy on zero tolerance of abuse and neglect for 2021 was not completed and the DOC acknowledged it.

Sources: Programs Evaluation Records, and interview with the DOC. [s. 99. (b)]

Issued on this 1st day of April, 2022

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

Original report signed by the inspector.