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

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 rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 28, 2021	2021_631210_0025	015568-20, 007889-21	Complaint

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

SLAVICA VUCKO (210)

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): September 27, 28, 29, October 4, 5 and 6, 2021.

The following intakes were completed during this complaint inspection:
-Log #007889-21 and # 015568-20 related to alleged abuse.

During the course of the inspection, the inspector conducted observations of the home, including resident home areas, staff to resident interactions, reviewed internal investigation notes, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Physiotherapist (PT), Environmental Services Manager (ESM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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 O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

A complaint was submitted to Ministry of Long-Term Care (MLTC) about an injury that resident #003 sustained soon after their admission at the home.

On a specified date, resident #003 was discovered with an injury. The resident presented with responsive behaviour, was at risk for falls and tended to grab objects in their hands tightly.

During interviews with staff who were involved in the care of resident #003, different answers were provided in regards to the status of resident #003’s bed rails and their positioning. One PSW assumed that during admission resident #003 required full bed rails and did not question registered staff about the bed rails. The Physiotherapist (PT) assessed the resident but did not mention the use of bed rails.

Annual dimensional bed measurements were carried out, which showed some full bed rails were disabled on one or both sides. Resident #003 was discharged from the home. Other residents' beds were observed and two residents' bed rails did not match the bed measurement documentation, and there was no bed rail assessment conducted.

There was no documentation in three residents' clinical records to indicate the residents were assessed, and had their bed systems evaluated, in order to minimize risk to the residents.

The bed systems (including the assistive aids and devices such as bed rails, pads, etc) of three residents were not evaluated to be appropriate for the residents.

Sources: review of residents’ clinical records, interview with registered and other staff, review of Guidance document: Adult Hospital Beds-Patient Entrapment, Hazards, Side Rail Latching Reliability, and Other Hazards issued by Health Canada 2008, FDA- A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment issued June 21, 2006, and review of home’s policies and procedures. [s. 15. (1) (a)]

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 where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #2: 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 resident #003 and their substitute decision-maker (SDM) had been provided the opportunity to participate fully in the development and implementation of the plan of care.

A complaint was submitted to MLTC about an injury of resident #003 and SDM was informed one day after the injury was sustained.

Resident #003 was discovered with an injury on a specified date in evening and their SDM was informed the following day.

Sources: interview with registered staff and other staff, interview with family member, review of resident #003's clinical record, home's policies and procedures. [s. 6. (5)]

Issued on this 29th day of October, 2021

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

Original report signed by the inspector.