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
Feb 4, 2019	2018_493652_0016	009828-18, 010016-18, 017804-18	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): November 2, 5, 6, 7, 8, 13 and 14, 2018

The following complaint inspection (CO) was conducted:

Log #009828-18, #008928-18 and #010016-18 related to the provision of care.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), assistant director of care (ADOC), nurse managers (NM), registered nursing staff, personal support worker (PSWs), social worker (SW), psychiatrist, behaviour support lead, falls prevention lead, consultant pharmacist, physiotherapist (PT) substitute decision-maker (SDM).

During the course of the inspection, the inspector conducted a tour of the home; observed staff to resident interactions and the provision of care, resident to resident interactions; reviewed the home's complaints records, conducted records review, reviewed the home's policy for complaints and reporting, responsive behaviours, medication management and prevention of abuse and neglect.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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 :

The Licensee failed to ensure the care set out in the plan of care was provided to the

resident as specified in the plan.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint on an identified date related to the care provided to resident #001.

MOHLTC received video footages on an identified date and time. Video footage #1 revealed PSW #100 was assigned to resident #001 as the one to one care staff. In the video footage PSW #100 was sitting on a chair close to the door in an identified location and resident #001 was standing nearby. PSW #100 looked over to resident #001 and observed that they were with what appeared to be, engaged in a responsive behaviour. PSW#100 walked over to resident #001 saying "don't do that", as they attempted to hold resident #001's identified body part. Resident #001 released their identified body part and walked over towards the window. PSW #100 then grabbed resident #001 and walked them towards an identified location. Resident #001 resisted going towards the identified location and PSW #100 grabbed resident #001 and took them into the identified location, turned the light on and closed the door. Video #2 footage revealed resident #001 and PSW #100 were still in the identified location with the door closed when resident #100 spoke in a very loud tone in what appears to be another language.

Record review of resident #001's written plan of care on an identified date indicated resident #001 had an identified behavioural symptom and staff to ensure they have resident #001's attention before speaking or touching them. This written plan of care also directed staff to always approach resident with a calm, cool demeanor, speaking softly and encouraging the resident also be cognizant of not invading resident's personal space.

Record review of resident #001's kardex which summarizes the care needs of the resident, indicated,staff to ensure they have the resident's attention before speaking or touching and be cognizant of not invading resident #001's personal space.

In an interview PSW #100 indicated the rationale for their approach with resident #001 was to quickly disengage the resident from the responsive behaviour and to avoid an infection prevention and control issue.

In an interview assistant director of care #101 verified PSW #100 should have used a better approach to assist resident #001.

PSW #100 failed to provide care as set out in the plan of care on an identified date, when

the PSW did not approach resident #001 in a calm demeanor, grab the resident's attention or be congizant of not invading the resident's personal space.

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. 7. Nothing in this Act authorizes a licensee to assess a resident's requirements without the resident's consent or to provide care or services to a resident without the resident's consent. 2007, c. 8, s. 7.

Findings/Faits saillants :

The licensee has failed to comply with LTCHA, 2007, c. 8, s. 7.Nothing in this Act authorizes a licensee to assess a resident's requirements without the resident's consent or to provide care or services to a resident without the resident's consent. 2007, c. 8, s. 7

Record review of resident #001's Medication Administration Record (MAR) from the nursing home resident #001 resided in prior to admission to Downsview Long Term Care (DLTC) on an identified date indicated an order for an identified medication for identified symptoms. This MAR also indicated resident #001 was administered this medication on an identified date.

Resident #001 was admitted to DLTC on an identified date.

Record review of resident #001's New Admission Order Form on an identified date, indicated an order for an identified medication for identified symptoms as needed (PRN)

Record review of resident #001's timeline for the medication profile provided by the home's consulting pharmacy indicated identified dates resident #001's identified medication had been ordered and discontinued since admission to DLTC.

Record review of resident #001's SDM's email communications to assistant director of care #101 on an identified date, indicated that resident #001 cannot be given the identified medication as it had severe side effects and MD #105 had also stopped the identified medication.

Record review of resident #001's physician orders on an identified date, indicated an order for the identified medication daily for an identified symptom. This physician order also indicated an order for the identified medication daily and (continue PRN).

Record review of resident #001's medication administration record (MAR) for an identified date, indicated resident #001 had an order for the identified medication daily PRN for an identified symptom which was administered on three identified dates. This MAR also indicated an order for the identified medication daily; "continue PRN " which was administered on five identified dates.

Interview with RN #107 indicated resident #001's SDM requested to have the identified medication discontinued. The identified medication was continued as an option to manage resident #001's identified symptoms.

Interview with DOC indicated the SDM was not acting in the interest of resident #001 so the team made the decision to act in the best interest of the resident as the medication helped resident #001 to live a dignified life.

The home failed to get the consent of resident #001's SDM for the identified medication on an identified date.

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 consent to provide care is received from the resident or substitute decision maker, to be implemented voluntarily.

WN #3: 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 :

The licensee has failed to ensure that any written complaints that have been received concerning the care of a resident or the operation of the home has immediately been forwarded to the Director.

A complaint submitted to the MOHLTC on an identified date, indicated the SDM forwarded their concerns in writing to the home regarding the care provided to resident #001.

Review of the home's email communications to resident #001's SDM indicated the home responded to resident #001's substitute decision maker's concerns in a timely manner via emails, however, the home did not ensure that those written complaints were forwarded to the Director.

Interview with the assistant director of care and the Executive Director verified that the written complaints were not forwarded to the Director.

Issued on this 12th day of February, 2019

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

Original report signed by the inspector.