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
Jun 4, 2020	2020_816722_0007	009094-20	Complaint

Licensee/Titulaire de permis

Gem Health Care Group Limited
470 Raglan Street North RENFREW ON K7V 1P5

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), JOY IERACI (665)

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): On-site: May 8, and 12-13, 2020. Off-site: May 14-15, and 18-19, 2020.

Complaint log #009094-20 was inspected during this inspection related to various concerns with resident care and infection prevention and control procedures in the home during the COVID-19 outbreak.

During the course of this inspection, resident care and resident home areas (RHAs) were observed, and electronic and paper health records were reviewed. Provincial directives related to COVID-19 and long-term care homes were also reviewed.

During the course of the inspection, the inspector(s) spoke with Officers of the Licensee, the Administrator, the Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Dietitian (RD), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides (DAs), and residents. Inspectors also spoke with individuals who were not staff of the home, including the Chief Executive Officer (CEO), Medical Doctors (MDs) and RNs from Humber River Hospital (HRH); the Care Coordinator from the Central Local Health Integration Network (Central LHIN); and volunteers in the home.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 VPC(s)**
- **3 CO(s)**
- **1 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

The Ministry of Long-Term Care (MLTC) received a complaint regarding concerns with

resident care, the condition of the home, and various infection prevention and control (IPAC) issues.

The COVID-19 outbreak was declared in the home by Toronto Public Health on April 17, 2020, when the first lab-confirmed case of COVID-19 was identified in a resident. A review of the home's COVID-19 updates on their website indicated that, as of May 14, 2020, there were 83 residents and 99 staff who had tested positive for COVID-19. Of the 83 cases among residents, 40 had died due to COVID-19. These findings were confirmed in an interview with GEM Healthcare Corporation Chief Operating Officer (COO) #125.

In an interview, HRH staff #124 indicated that the hospital was assigned to support the home in managing their COVID-19 outbreak. HRH had deployed staff to the home on a specified date after the COIVD-19 outbreak was declared to conduct an on-site assessment. HRH staff #124 had concerns regarding the cleanliness of the home, increasing number of resident cases and deaths, inappropriate use of personal protective equipment (PPE) by staff, and various Infection Prevention and Control (IPAC) concerns.

A letter from HRH to the home's Administrator #101 was reviewed, which outlined the following findings and concerns from HRH's on-site assessment:
- Residents were observed dining in a congregate setting with limited social distancing;
- Staff did not appear to be following PPE recommendations (e.g., some staff wearing garbage bags, face shields not being used);
- No apparent established process in place for staff illness tracking and reporting;
- Did not observe posting of donning/doffing instructions throughout facility;
- Not all residents who were positive for COVID-19 were cohorted;
- Soiled linen stored next to uncovered clean linen;
- Inconsistencies in PPE being worn by staff;
- Point of Care Risk Assessment (PCRA) education lacking;
- Universal masking not consistent throughout home;
- Social distancing not occurring with both patients and staff;
- No one individual initially identified from management team as responsible for leading outbreak management;
- No multidisciplinary planning committee or team created to address preparedness planning;
- Dedicated care equipment not being used;
- Cohorting of staff and patients lacking;

- Not enough garbage bins throughout home;
- Droplet/contact precautions signage lacking;
- Twice daily cleaning recently scaled back due to staffing issues; and
- Concerns about end-of-life directives for residents.

The Chief Medical Officer of Health (CMOH) issued Directive #3 for Long-Term Care Homes on March 22, 2020, which has been re-issued with revisions on March 30, April 8 and 15, and May 21 and 23, 2020. At the time of this inspection, Directive #3 indicated the urgent requirement for long-term care homes (LTCHs) to implement additional measures for the protection of staff and residents from COVID-19.

1. Directive #3 directed LTCHs to implement active screening of all staff and essential visitors entering the home, which included temperature checks twice daily, at the beginning and end of the day or shift, which was not being done consistently in the home.

On a specified date, Inspector #722 was exiting the home and no staff were present in the front lobby to screen for COVID-19 signs and symptoms upon exit. A staff person arrived and screened the inspector when requested. On a later specified date, the inspector observed that approximately 10 or more staff and other essential visitors were not actively screened upon leaving the building; there were no temperature checks, and they were not required to complete the form for self-reporting symptoms, travel history, or possible exposure to a COVID-19 case.

PSW #120 confirmed in an interview that staff were only screened once per day, when they entered the building for their shift. The staff member responsible for screening, PSW #122, was interviewed and confirmed that they typically only screened staff and essential visitors on entry to the building. They were not aware that staff should be screened at the end of their shift.

Administrator #101 and ADOC #103 confirmed in interviews that active screening was implemented on a specified date for all staff and essential visitors entering the home with temperature checks. However, they acknowledged that the home had not implemented active screening of all staff and essential visitors upon exiting the home.

2. Directive #3 required LTCHs to implement physical distancing and cohorting where possible among staff and residents to prevent the spread of COVID-19. Evidence indicated that this was not implemented consistently throughout the home.

On two specified dates, Inspector #722 observed a lack of social distancing in the home, involving both staff and residents. Staff were frequently observed congregated in common areas, huddled together and walking together. Residents were observed sitting or walking together in common areas; for example, two residents were observed sitting in chairs side by side in front of the nursing station in a specified resident home area (RHA). On both dates, the inspector also observed that residents in another specified RHA were having meals in the dining room, which appeared crowded with 12-14 residents and three staff (2 PSWs, 1 DA); and three residents were observed seated together at some tables.

PSW #116 and DA #117 both acknowledged in separate interviews that social distancing among residents and staff was difficult in the home due to narrow hallways, accumulation of equipment and supplies (e.g., PPE, garbages, linen carts, equipment, etc.), as well as basic requirements of duties (e.g., two staff needed to turn a resident, distributing meals in dining room). They both acknowledged that efforts were not made to encourage social distancing among residents, and that residents in the specified RHA continued to have congregate meals in the unit dining room. RN #118 indicated in an interview that MD #104 had advised that residents needed to have their meals in their rooms to maintain social distancing, but stated that it had not been arranged by management.

Administrator #101 and ADOC #103 indicated during interviews that the home was able to cohort residents who had COVID-19 from the well residents at the beginning of the outbreak; however, they stated that as the outbreak progressed with increasing numbers of COVID-19 cases among residents and staff, it became difficult to cohort the residents. ADOC #103 indicated that the HRH team completed an IPAC assessment in late April 2020, and acknowledged that social distancing in the home was an identified issue, specifically in the dining rooms, and that it was suggested that residents should be eating in their rooms. The ADOC confirmed that they continued to have residents in a specified RHA have meals in the dining room to maintain normalcy for a specified reason, and because they did not have the equipment to support residents to have meals in their rooms.

3. Directive #3 indicated that LTCHs needed to ensure they were prepared for COVID-19, including review of advanced directives for all residents.

During an interview, MD #104 from HRH indicated that they were concerned that the levels of care and medical directives had not been recently reviewed; they stated that it

did not look like those conversations had occurred for a number of years and, if they did occur, they were not documented in a way that was clear.

In an interview, ADOC #103 indicated that the home's social worker communicated with residents' families to discuss advanced care planning on admission and annually. The ADOC acknowledged that reviewing residents' advanced care directives has been a weakness of the home. They indicated that the home had not reviewed the advanced care directives of all residents for COVID-19 preparedness. It was only when the HRH staff were deployed to the home that advanced care directives were being reviewed.

In an interview, Administrator #101 confirmed that a review of the residents' advanced care directives was not conducted to prepare for COVID-19. The Administrator indicated that it was the responsibility of the physicians in the home to review that with the families, which was not completed consistently.

4. Directive #3 directed LTCHs to ensure appropriate personal protective equipment (PPE) was available, and LTCH staff were expected to follow Directive #1 for Health Care Providers and Health Care Entities.

Directive #1 for Health Care Providers and Health Care Entities issued March 30, 2020, which was in place at the time of this inspection, directed that a point-of-care risk assessment (PCRA) must be performed by every health care worker before every patient interaction.

The HRH letter that was reviewed, and described above, indicated that PCRA education was lacking in the home.

In an interview, ADOC #103 indicated that it was the home's process for the registered staff to report to PSWs at the beginning of the shift residents that required isolation and those who had symptoms. From the report, the PSWs and registered staff would be aware of the PPE to be used prior to resident care. The ADOC acknowledged that there was no education provided to the staff on PCRA in preparation for COVID-19.

5. Directive #5 was issued by the CMOH on March 30, which was revised on April 10, 2020, to further protect health care workers' health and safety in the use of any protective clothing, equipment and device. This version was in effect at the time of this inspection.

On two specified dates, Inspector #722 observed staff wearing full PPE for

droplet/contact precautions (gowns, gloves, N95 masks and face shields) in hallways throughout the home and entering and leaving residents' rooms without appropriate donning and doffing methods. Specifically, staff were observed going in/out of resident rooms without changing gowns or masks in a specified RHA on a specified date. Staff were also observed wearing double masks, usually a surgical mask over an N95 mask.

On a specified date, RPN #109 was observed entering resident #004's room without a gown; the RPN was wearing a mask and gloves. The RPN acknowledged in an interview that they were aware the resident was receiving a specified treatment and had potential symptoms of COVID-19. They stated the resident had tested negative for COVID-19 previously, but the resident's condition had changed and they were not sure about the resident's status now. There was no sign on the resident's door or PPE near the room which indicated any additional precautions were required. Record review confirmed that resident #004 had symptoms potentially due to COVID-19, and an interview with Central LHIN Care Coordinator #107 confirmed that the resident would have been a probable case of COVID-19, and they could not explain why there was no signage or PPE at the resident's room.

On another specified date, the inspector observed RPN #115 providing medications to a resident in a specified room, wearing full PPE for droplet/contact precautions. When they left the room, the RPN only removed their gloves, performed hand hygiene, applied a new pair of gloves, and entered the same room to assist with care for another resident. RPN #115 indicated in an interview that there were no residents in the room who were positive for COVID-19, and that their usual procedure was to only change their gloves. They acknowledged that they did not change their gown or mask, as those were the instructions provided by the IPAC team from HRH.

Several staff of the home were interviewed and indicated that the hospital IPAC team had advised them to wear full contact/droplet PPE in all areas of the home at all times. This direction created confusion among staff around when and what PPE to donn/doff when they provided care to residents. RN #106 and #112 from HRH, as well as ADOC #103, were interviewed separately and confirmed that the staff were advised to wear full droplet/contact PPE throughout the home, in an effort to reduce spread by treating all residents as though they were positive for COVID-19.

During observations on a specified date, Inspector #722 identified that a number of residents who were positive for COVID-19 did not have appropriate signage identifying the required precautions (i.e., droplet/contact), and PPE and/or garbage containers were

not available outside rooms for donning and doffing PPEs. This was observed throughout the home, specifically for five identified resident rooms. Inspector #722 asked RPN #113 about the PPE for residents in two identified rooms, and the RPN acknowledged that residents in those rooms were positive for COVID-19 and there should have been PPE available outside the room.

In an interview, HRH staff #124 stated that there were a number of IPAC concerns in the home, which included staff wearing garbage bags over their isolation gowns and fans in the units were running. The HRH IPAC team advised the home to turn off the fans, with several calls made to the home to turn the fans off when HRH staff observed the fans running. The fans were disconnected on a later specified date.

In an interview, Administrator #101 confirmed that some PSWs wore garbage bags over their isolation gowns out of fear of COVID-19. The home followed up with the PSWs to stop this practice after it was brought to their attention by HRH. They also indicated that after HRH staff told them to turn off the fans in the units and the staff kept turning them on. On a later specified date, maintenance disconnected the fans in the units and removed them from the walls.

6. The licensee was not notified by the Administrator regarding critical issues in the home associated with the COVID-19 outbreak.

In an interview, HRH staff #124 indicated that they were concerned about the poor care conditions of the home and informed the Chief Executive Officer (CEO) #126 of GEM Health Care Corporation on a specified date.

In interviews with CEO #126 and Chief Operating Officer (COO) #125 of GEM Health Care Corporation, both indicated that they were not aware of the situation at the home until they received a call from HRH staff #124 on a specified date. Prior to the call, the Administrator had only informed them of their ongoing challenge with staffing as a result of their COVID-19 outbreak.

The CEO indicated that they had sent the COO to visit the home and received a report that there was a lack of cleaning staff in the home, lack of physicians for the residents, and that there were many residents who were sick with COVID-19. The CEO confirmed that this information was not provided to them from the Administrator of the home.

The COO confirmed that they had gone in the home on a specified date and observed

many residents were sick and there were many empty resident beds. They were not aware of the situation at the home until the call from HRH staff #124 on the specified date.

7. Humber River Hospital (HRH) staff identified concerns with overall cleanliness of the home.

HRH staff #124 indicated in an interview that they had concerns with the overall cleanliness of the home and had arranged for a cleaning agency to clean and disinfect the home.

Administrator #101 and ADOC #103 indicated in interviews that the home was not being cleaned as usual for a specified reason related to COVID-19. They acknowledged that the home did not have the staff to clean and clear resident rooms until a specified period. The Administrator confirmed that the home had not arranged an external agency to provide cleaning services, and that HRH staff #124 arranged an external cleaning agency to clean and disinfect the facility on a specified date.

8. HRH staff identified concerns related to nutrition and hydration in the home that posed a safety risk to residents.

MD #104 from HRH indicated that when they arrived at the home on a specified date they observed concerns related to nutrition and hydration, specifically that residents were not being fed appropriately, or receiving sufficient fluids. MD #104 and MD #105 both indicated in separate interviews that they observed signs of dehydration in residents during their assessments.

RN #106 from HRH was interviewed, and indicated that the HRH staff observed that residents were not receiving the appropriate diets; specifically, some residents who were on pureed diet would receive regular texture, and vice versa. The RN indicated that, because of this, resident diet orders were posted on the door of their room to protect residents during the COVID-19 outbreak. They also observed several residents who were receiving hypodermoclysis, and their fluid administration bags were empty.

On two specified dates, Inspector #722 made observations in the home and identified that resident diet orders had been posted on the doors, which specified the residents' diet type and texture.

PSW #130 was interviewed and confirmed that due to staff shortages, resident care was not provided as usual, and confirmed that there were occasions when residents did not receive diets as ordered due to confusion among staff, specifically volunteers, and residents received the incorrect texture of diet.

ADOC #103 was interviewed and acknowledged that resident care declined after the COVID-19 outbreak was declared in the home due to critical staffing shortages.

The licensee failed to ensure that the home was a safe environment for the residents when it failed to implement required provincial directives during the COVID-19 outbreak, including the following: active screening of their staff, staff and resident cohorting, lack of preparation for COVID-19 related to residents' advanced care directives, concerns with the appropriate use of PPE, lack of adequate environmental cleaning and following IPAC practices to protect residents and staff from COVID-19 infection. [s. 5.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002 received end-of-life care when it was required in a manner that met the resident's needs.

The MLTC received a complaint that resident #002 was not administered a specified medication as prescribed to promote resident comfort while they were in the process of dying.

Review of the progress notes indicated that resident #002 had a specified condition and

their health status continued to decline over a specified period.

Review of the physician orders indicated that on a specified date, MD #104 ordered a specified drug for a specified condition. A Memo from the home's pharmacy identified that the resident had an identified condition that required caution when administering the ordered drug; it did not specify that the ordered drug was contraindicated.

The progress notes were reviewed for resident #002. On a specified date after the drug was initially ordered, an entry indicated the resident was administered a dose of the drug at a specified time "with good effect", and a note entered later by MD #104 indicated that the ordered drug had the desired effect on the resident. On a later specified date and at two specified times during a shift, RN #123 indicated in the progress notes that resident #002 was exhibiting signs and symptoms that were consistent with the indication for the ordered drug. There was no indication in the progress notes that the drug was administered as ordered. Review of the medication administration record and other specified records for resident #002 confirmed that the drug was not administered.

RN #123, Nurse Manager, was interviewed and confirmed that they were working on the specified shift, that resident #002 was exhibiting specified signs and symptom, and that they did not administer the drug as ordered. They indicated that they were the only RN for two units, responsible for approximately 57 residents, and that they likely did not administer the drug because they were too busy.

ADOC #103 was interviewed and acknowledged that the expectation was that drugs ordered to promote resident comfort while they were dying should be administered as ordered. The ADOC indicated that registered staff had attended their office soon after the HRH staff arrived at the home, and refused to administer certain specified drugs on the grounds that they were hastening resident death. They acknowledged that additional training in palliative care was required to ensure registered staff in the home would feel comfortable administering medications as ordered to promote resident comfort while they were dying.

These findings show that resident #002 did not receive end-of-life care when it was required in a manner that met their needs when they were not administered a specified drug as ordered during a specified shift. [s. 42.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that, on every shift, symptoms indicating the presence of COVID-19 infection were recorded for resident #002 and that immediate action was taken as required.

A complaint was received by the MLTC related to overall care of residents in the home, and specifically involving resident #002.

In an interview, HRH MD #104 indicated that they attended rounds with staff in the home on a specified date and time and resident #002, who had a specified condition, was found with identified signs and symptoms that suggested a significant change in health status. The physician was concerned that the resident had not been assessed, appropriate care had not been provided during the night shift or morning, and that medical personnel had not been notified of the resident's change in condition.

Review of resident #002's care plan indicated that the resident had a specified health condition, and that staff were expected to monitor and report mild to severe symptoms of the condition.

The vital signs and assessments were reviewed in the electronic health record, and there was no documentation which indicated that the resident's vital signs had been measured, or that the resident had been assessed for their change in condition.

Review of the progress notes indicated that resident #002 had a specified health

condition, and that the resident was declining over several identified days; however, there were no assessment findings entered in the progress notes over this period, including documentation of vital signs, or any other signs or symptoms of the condition. On a specified date at two specified times, RPN #121 made two entries in the progress notes related to the resident; however, there was no indication in either of the progress notes about the resident's condition, their vital signs, that any actions had been taken, or that medical staff had been notified about the resident's change in condition. There were no further entries in the progress notes until the late morning the next day, when RPN #121 entered that they had done rounds with MD #104. They noted that at that time that resident #002 had specified signs and symptoms which indicated that the resident had a significant change in condition, and documented the action that was taken.

Further review of progress notes indicated that MD #104 made an entry which indicated that resident #002 was seen on rounds with the HRH Outreach Team and had a specified condition. MD #104 indicated that resident #002 had specified signs and symptoms that indicated a significant change in the resident's health status. They indicated in their note that they spoke with the resident's substitute decision maker (SDM) about the resident's condition and prognosis.

ADOC #103 was interviewed and confirmed that RPNs were expected to notify nurse managers and physicians when a resident's condition changed. The ADOC acknowledged that there were no vital signs for the resident documented in a flow sheet outside of the electronic health record. They also acknowledged that the resident's status appeared to change significantly during the night shift and early day shift on the specified dates, the resident should have been assessed, and physician should have been notified. Inspector #722 made multiple attempts to contact RPN #121, who was responsible for resident #002's care on the specified dates, and they could not be reached.

Based on the evidence above, there was no indication that resident #002 had their symptoms of infection assessed on the specified dates, or that immediate action was taken as required due to the resident's significant change in condition. [s. 229. (5) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents of the home, specifically residents #002 and #003, received oral care to maintain the integrity of the oral tissue which included mouth care in the morning and evening.

The MLTC received a complaint related to lack of oral care for residents in the home.

The care plans were reviewed for residents #002 and #003 related to oral care, and both residents required assistance as detailed in the care plan. Review of the Observation/Flow Sheet Monitoring Form for both residents indicated that provision of oral care was not documented consistently during a specified period.

MD #104 was interviewed and indicated that they initially arrived in the home on a specified date as part of a team from HRH, and that they returned to the home to assist in clinical duties on later specified dates. MD #104 expressed concern about the overall care of residents. Specifically, the MD identified that some residents appeared to have oral health problems and that oral care was lacking. MD #104 specifically made reference to residents #002 and #003.

RN #106 from HRH was interviewed, and indicated that the HRH staff observed poor oral care for a number of residents, including finding old food and medications in residents' mouths who had not had any food by mouth for several days due to their condition.

PSW #130 was interviewed, and confirmed that during the COVID-19 outbreak in the home, resident care was not provided as usual due to lack of staffing, and stated that residents did not receive the one-to-one care they needed until additional staff arrived in the home to assist with care. The PSW indicated that when they were critically short of staff on shifts, oral care did not get done, and specifically identified that was the case for residents #002 and #003.

ADOC #103 was interviewed and acknowledged that resident care declined after the COVID-19 outbreak was declared in the home on April 17, 2020, due to critical staffing shortages. They acknowledged that during that period of time, basic care was likely not getting done, and that staff were upset that they were not able to spend the time with residents to provide the required care. They stated that only the basics were getting done, including feeding and changing.

Inspector #722 made observations on two specified dates and identified personnel throughout the home providing oral care, and oral care stations (swabs, mouthwash, etc.) set up in each unit.

The evidence above supports the finding that residents in the home, specifically residents #002 and #003, did not receive appropriate oral care to maintain the integrity of the oral tissue, which included mouth care in the morning and evening. [s. 34. (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 residents of the home receive oral care to maintain the integrity of the oral tissue, which includes physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth, to be implemented voluntarily.

Issued on this 15th day of June, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	COREY GREEN (722), JOY IERACI (665)
Inspection No. / No de l'inspection :	2020_816722_0007
Log No. / No de registre :	009094-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 4, 2020
Licensee / Titulaire de permis :	Gem Health Care Group Limited 470 Raglan Street North, RENFREW, ON, K7V-1P5
LTC Home / Foyer de SLD :	Downsview Long Term Care Centre 3595 Keele Street, NORTH YORK, ON, M3J-1M7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Ruben Rodriguez

To Gem Health Care Group Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must be compliant with s. 5 of the LTCHA.

The licensee shall prepare, submit, and implement a plan to ensure:

1. All requirements specified by the Chief Medical Officer of Health (CMOH) in the latest version of Directive #3 for Long-Term Care Homes for COVID-19 are implemented in the home. Specifically, the licensee must ensure:
(a) Active screening of all staff and essential visitors as specified in the directive, including maintaining all records to show that they were screened on entry and on exit from the home;
(b) Social distancing among staff and visitors in the home, to the extent possible;
(c) Cohorting of affected and unaffected residents and staff in the home to the extent possible;
(d) All routine congregate dining in the home is ceased immediately, and residents have their meals in their rooms;
(e) When congregate dining is reestablished, or residents with cognitive impairment prefer to eat in the dining room, ensure social distancing is maintained;
(f) Hallways are cleared of unnecessary equipment and supplies to the extent possible, to facilitate social distancing; and
(g) Routine home audits are conducted to ensure these measures have been put in place.

2. All residents' advanced directives are current and up-to-date; including reviewing resident records and consultation with substitute decision-makers as applicable. The home will conduct an audit of resident records to ensure that advanced directives are current for every resident in the home.

3. All requirements specified by the CMOH in latest version of Directive #3 related to appropriate use of Personal Protective Equipment (PPE), as specified in Directive #1 for Health Care Providers and Health Care Entities, are implemented in the home. Specifically, the licensee must ensure that:
(a) All staff in the home receive appropriate training related to conducting point-of-care risk assessments (PCRA) to determine appropriate use of PPEs;
(b) Appropriate infection prevention and control (IPAC) signage and PPE supplies available outside each resident room for residents with probable or confirmed COVID-19 infection, including adequate garbage bins for doffing PPEs;
(c) All staff receive training on the appropriate use of PPE, including appropriate donning and doffing methods, based on IPAC instructions provided by the local hospital, public health, and directions provided in IPAC assessments;
(d) Routine audits are conducted in the home to ensure that these requirements are being met.

4. The Administrator of the home notifies the licensee of critical issues in the home.

5. Nutrition and hydration needs of all residents in the home are met. Specifically, the licensee must ensure that:
(a) All residents receive the appropriate diet and texture according to their plan of care;
(b) All residents receive the assistance and support they require to maintain adequate food and fluid intake according to their plan of care;
(c) Fluid administration bags are appropriately monitored and replaced as required; and
(d) Routine audits are conducted by management of the home to ensure that these requirements are being met.

6. Maintain a record of all audits required in this order, which must be made available to the inspector when requested in the follow-up inspection.

Please submit the written plan for achieving compliance for inspection #2020_816722_0007 to Corey Green, LTC Homes Inspector, MLTC, by email to torontosao.moh@ontario.ca by June 18, 2020. Please ensure that the

submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

The Ministry of Long-Term Care (MLTC) received a complaint regarding concerns with resident care, the condition of the home, and various infection prevention and control (IPAC) issues.

The COVID-19 outbreak was declared in the home by Toronto Public Health on April 17, 2020, when the first lab-confirmed case of COVID-19 was identified in a resident. A review of the home's COVID-19 updates on their website indicated that, as of May 14, 2020, there were 83 residents and 99 staff who had tested positive for COVID-19. Of the 83 cases among residents, 40 had died due to COVID-19. These findings were confirmed in an interview with GEM Healthcare Corporation Chief Operating Officer (COO) #125.

In an interview, HRH staff #124 indicated that the hospital was assigned to support the home in managing their COVID-19 outbreak. HRH had deployed staff to the home on a specified date after the COIVD-19 outbreak was declared to conduct an on-site assessment. HRH staff #124 had concerns regarding the cleanliness of the home, increasing number of resident cases and deaths, inappropriate use of personal protective equipment (PPE) by staff, and various Infection Prevention and Control (IPAC) concerns.

A letter from HRH to the home's Administrator #101 was reviewed, which outlined the following findings and concerns from HRH's on-site assessment:
- Residents were observed dining in a congregate setting with limited social distancing;
- Staff did not appear to be following PPE recommendations (e.g., some staff wearing garbage bags, face shields not being used);
- No apparent established process in place for staff illness tracking and reporting;
- Did not observe posting of donning/doffing instructions throughout facility;
- Not all residents who were positive for COVID-19 were cohorted;
- Soiled linen stored next to uncovered clean linen;

- Inconsistencies in PPE being worn by staff;
- Point of Care Risk Assessment (PCRA) education lacking;
- Universal masking not consistent throughout home;
- Social distancing not occurring with both patients and staff;
- No one individual initially identified from management team as responsible for leading outbreak management;
- No multidisciplinary planning committee or team created to address preparedness planning;
- Dedicated care equipment not being used;
- Cohorting of staff and patients lacking;
- Not enough garbage bins throughout home;
- Droplet/contact precautions signage lacking;
- Twice daily cleaning recently scaled back due to staffing issues; and
- Concerns about end-of-life directives for residents.

The Chief Medical Officer of Health (CMOH) issued Directive #3 for Long-Term Care Homes on March 22, 2020, which has been re-issued with revisions on March 30, April 8 and 15, and May 21 and 23, 2020. At the time of this inspection, Directive #3 indicated the urgent requirement for long-term care homes (LTCHs) to implement additional measures for the protection of staff and residents from COVID-19.

1. Directive #3 directed LTCHs to implement active screening of all staff and essential visitors entering the home, which included temperature checks twice daily, at the beginning and end of the day or shift, which was not being done consistently in the home.

On a specified date, Inspector #722 was exiting the home and no staff were present in the front lobby to screen for COVID-19 signs and symptoms upon exit. A staff person arrived and screened the inspector when requested. On a later specified date, the inspector observed that approximately 10 or more staff and other essential visitors were not actively screened upon leaving the building; there were no temperature checks, and they were not required to complete the form for self-reporting symptoms, travel history, or possible exposure to a COVID-19 case.

PSW #120 confirmed in an interview that staff were only screened once per day,

when they entered the building for their shift. The staff member responsible for screening, PSW #122, was interviewed and confirmed that they typically only screened staff and essential visitors on entry to the building. They were not aware that staff should be screened at the end of their shift.

Administrator #101 and ADOC #103 confirmed in interviews that active screening was implemented on a specified date for all staff and essential visitors entering the home with temperature checks. However, they acknowledged that the home had not implemented active screening of all staff and essential visitors upon exiting the home.

2. Directive #3 required LTCHs to implement physical distancing and cohorting where possible among staff and residents to prevent the spread of COVID-19. Evidence indicated that this was not implemented consistently throughout the home.

On two specified dates, Inspector #722 observed a lack of social distancing in the home, involving both staff and residents. Staff were frequently observed congregated in common areas, huddled together and walking together. Residents were observed sitting or walking together in common areas; for example, two residents were observed sitting in chairs side by side in front of the nursing station in a specified resident home area (RHA). On both dates, the inspector also observed that residents in another specified RHA were having meals in the dining room, which appeared crowded with 12-14 residents and three staff (2 PSWs, 1 DA); and three residents were observed seated together at some tables.

PSW #116 and DA #117 both acknowledged in separate interviews that social distancing among residents and staff was difficult in the home due to narrow hallways, accumulation of equipment and supplies (e.g., PPE, garbages, linen carts, equipment, etc.), as well as basic requirements of duties (e.g., two staff needed to turn a resident, distributing meals in dining room). They both acknowledged that efforts were not made to encourage social distancing among residents, and that residents in the specified RHA continued to have congregate meals in the unit dining room. RN #118 indicated in an interview that MD #104 had advised that residents needed to have their meals in their rooms to maintain social distancing, but stated that it had not been arranged by management.

Administrator #101 and ADOC #103 indicated during interviews that the home was able to cohort residents who had COVID-19 from the well residents at the beginning of the outbreak; however, they stated that as the outbreak progressed with increasing numbers of COVID-19 cases among residents and staff, it became difficult to cohort the residents. ADOC #103 indicated that the HRH team completed an IPAC assessment in late April 2020, and acknowledged that social distancing in the home was an identified issue, specifically in the dining rooms, and that it was suggested that residents should be eating in their rooms. The ADOC confirmed that they continued to have residents in a specified RHA have meals in the dining room to maintain normalcy for a specified reason, and because they did not have the equipment to support residents to have meals in their rooms.

3. Directive #3 indicated that LTCHs needed to ensure they were prepared for COVID-19, including review of advanced directives for all residents.

During an interview, MD #104 from HRH indicated that they were concerned that the levels of care and medical directives had not been recently reviewed; they stated that it did not look like those conversations had occurred for a number of years and, if they did occur, they were not documented in a way that was clear.

In an interview, ADOC #103 indicated that the home's social worker communicated with residents' families to discuss advanced care planning on admission and annually. The ADOC acknowledged that reviewing residents' advanced care directives has been a weakness of the home. They indicated that the home had not reviewed the advanced care directives of all residents for COVID-19 preparedness. It was only when the HRH staff were deployed to the home that advanced care directives were being reviewed.

In an interview, Administrator #101 confirmed that a review of the residents' advanced care directives was not conducted to prepare for COVID-19. The Administrator indicated that it was the responsibility of the physicians in the home to review that with the families, which was not completed consistently.

4. Directive #3 directed LTCHs to ensure appropriate personal protective equipment (PPE) was available, and LTCH staff were expected to follow

Directive #1 for Health Care Providers and Health Care Entities.

Directive #1 for Health Care Providers and Health Care Entities issued March 30, 2020, which was in place at the time of this inspection, directed that a point-of-care risk assessment (PCRA) must be performed by every health care worker before every patient interaction.

The HRH letter that was reviewed, and described above, indicated that PCRA education was lacking in the home.

In an interview, ADOC #103 indicated that it was the home's process for the registered staff to report to PSWs at the beginning of the shift residents that required isolation and those who had symptoms. From the report, the PSWs and registered staff would be aware of the PPE to be used prior to resident care. The ADOC acknowledged that there was no education provided to the staff on PCRA in preparation for COVID-19.

5. Directive #5 was issued by the CMOH on March 30, which was revised on April 10, 2020, to further protect health care workers' health and safety in the use of any protective clothing, equipment and device. This version was in effect at the time of this inspection.

On two specified dates, Inspector #722 observed staff wearing full PPE for droplet/contact precautions (gowns, gloves, N95 masks and face shields) in hallways throughout the home and entering and leaving residents' rooms without appropriate donning and doffing methods. Specifically, staff were observed going in/out of resident rooms without changing gowns or masks in a specified RHA on a specified date. Staff were also observed wearing double masks, usually a surgical mask over an N95 mask.

On a specified date, RPN #109 was observed entering resident #004's room without a gown; the RPN was wearing a mask and gloves. The RPN acknowledged in an interview that they were aware the resident was receiving a specified treatment and had potential symptoms of COVID-19. They stated the resident had tested negative for COVID-19 previously, but the resident's condition had changed and they were not sure about the resident's status now. There was no sign on the resident's door or PPE near the room which indicated

any additional precautions were required. Record review confirmed that resident #004 had symptoms potentially due to COVID-19, and an interview with Central LHIN Care Coordinator #107 confirmed that the resident would have been a probable case of COVID-19, and they could not explain why there was no signage or PPE at the resident's room.

On another specified date, the inspector observed RPN #115 providing medications to a resident in a specified room, wearing full PPE for droplet/contact precautions. When they left the room, the RPN only removed their gloves, performed hand hygiene, applied a new pair of gloves, and entered the same room to assist with care for another resident. RPN #115 indicated in an interview that there were no residents in the room who were positive for COVID-19, and that their usual procedure was to only change their gloves. They acknowledged that they did not change their gown or mask, as those were the instructions provided by the IPAC team from HRH.

Several staff of the home were interviewed and indicated that the hospital IPAC team had advised them to wear full contact/droplet PPE in all areas of the home at all times. This direction created confusion among staff around when and what PPE to donn/doff when they provided care to residents. RN #106 and #112 from HRH, as well as ADOC #103, were interviewed separately and confirmed that the staff were advised to wear full droplet/contact PPE throughout the home, in an effort to reduce spread by treating all residents as though they were positive for COVID-19.

During observations on a specified date, Inspector #722 identified that a number of residents who were positive for COVID-19 did not have appropriate signage identifying the required precautions (i.e., droplet/contact), and PPE and/or garbage containers were not available outside rooms for donning and doffing PPEs. This was observed throughout the home, specifically for five identified resident rooms. Inspector #722 asked RPN #113 about the PPE for residents in two identified rooms, and the RPN acknowledged that residents in those rooms were positive for COVID-19 and there should have been PPE available outside the room.

In an interview, HRH staff #124 stated that there were a number of IPAC concerns in the home, which included staff wearing garbage bags over their

isolation gowns and fans in the units were running. The HRH IPAC team advised the home to turn off the fans, with several calls made to the home to turn the fans off when HRH staff observed the fans running. The fans were disconnected on a later specified date.

In an interview, Administrator #101 confirmed that some PSWs wore garbage bags over their isolation gowns out of fear of COVID-19. The home followed up with the PSWs to stop this practice after it was brought to their attention by HRH. They also indicated that after HRH staff told them to turn off the fans in the units and the staff kept turning them on. On a later specified date, maintenance disconnected the fans in the units and removed them from the walls.

6. The licensee was not notified by the Administrator regarding critical issues in the home associated with the COVID-19 outbreak.

In an interview, HRH staff #124 indicated that they were concerned about the poor care conditions of the home and informed the Chief Executive Officer (CEO) #126 of GEM Health Care Corporation on a specified date.

In interviews with CEO #126 and Chief Operating Officer (COO) #125 of GEM Health Care Corporation, both indicated that they were not aware of the situation at the home until they received a call from HRH staff #124 on a specified date. Prior to the call, the Administrator had only informed them of their ongoing challenge with staffing as a result of their COVID-19 outbreak.

The CEO indicated that they had sent the COO to visit the home and received a report that there was a lack of cleaning staff in the home, lack of physicians for the residents, and that there were many residents who were sick with COVID-19. The CEO confirmed that this information was not provided to them from the Administrator of the home.

The COO confirmed that they had gone in the home on a specified date and observed many residents were sick and there were many empty resident beds. They were not aware of the situation at the home until the call from HRH staff #124 on the specified date.

7. Humber River Hospital (HRH) staff identified concerns with overall cleanliness

of the home.

HRH staff #124 indicated in an interview that they had concerns with the overall cleanliness of the home and had arranged for a cleaning agency to clean and disinfect the home.

Administrator #101 and ADOC #103 indicated in interviews that the home was not being cleaned as usual for a specified reason related to COVID-19. They acknowledged that the home did not have the staff to clean and clear resident rooms until a specified period. The Administrator confirmed that the home had not arranged an external agency to provide cleaning services, and that HRH staff #124 arranged an external cleaning agency to clean and disinfect the facility on a specified date.

8. HRH staff identified concerns related to nutrition and hydration in the home that posed a safety risk to residents.

MD #104 from HRH indicated that when they arrived at the home on a specified date they observed concerns related to nutrition and hydration, specifically that residents were not being fed appropriately, or receiving sufficient fluids. MD #104 and MD #105 both indicated in separate interviews that they observed signs of dehydration in residents during their assessments.

RN #106 from HRH was interviewed, and indicated that the HRH staff observed that residents were not receiving the appropriate diets; specifically, some residents who were on pureed diet would receive regular texture, and vice versa. The RN indicated that, because of this, resident diet orders were posted on the door of their room to protect residents during the COVID-19 outbreak. They also observed several residents who were receiving hypodermoclysis, and their fluid administration bags were empty.

On two specified dates, Inspector #722 made observations in the home and identified that resident diet orders had been posted on the doors, which specified the residents' diet type and texture.

PSW #130 was interviewed and confirmed that due to staff shortages, resident care was not provided as usual, and confirmed that there were occasions when

residents did not receive diets as ordered due to confusion among staff, specifically volunteers, and residents received the incorrect texture of diet.

ADOC #103 was interviewed and acknowledged that resident care declined after the COVID-19 outbreak was declared in the home due to critical staffing shortages.

The licensee failed to ensure that the home was a safe environment for the residents when it failed to implement required provincial directives during the COVID-19 outbreak, including the following: active screening of their staff, staff and resident cohorting, lack of preparation for COVID-19 related to residents' advanced care directives, concerns with the appropriate use of PPE, lack of adequate environmental cleaning and following IPAC practices to protect residents and staff from COVID-19 infection. [s. 5.]

The severity of this issue was determined to be a level 4 because there was significant actual harm to residents in the home. The scope of the issue was a level 3 because the issues identified were widespread in the home, potentially impacting all residents. The home had a level 2 compliance history as there were no prior non-compliances issued to this section of the legislation. (722)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 09, 2020

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Order / Ordre :

The licensee must be compliant with s. 42 of the Regulations.

Specifically, the licensee must ensure that all residents receive comfort measures and end-of-life care as specified in their plan of care, including administration of narcotic analgesics as ordered by the physician or nurse practitioner.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that resident #002 received end-of-life care when it was required in a manner that met the resident's needs.

The MLTC received a complaint that resident #002 was not administered a specified medication as prescribed to promote resident comfort while they were in the process of dying.

Review of the progress notes indicated that resident #002 had a specified condition and their health status continued to decline over a specified period.

Review of the physician orders indicated that on a specified date, MD #104 ordered a specified drug for a specified condition. A Memo from the home's pharmacy identified that the resident had an identified condition that required caution when administering the ordered drug; it did not specify that the ordered drug was contraindicated.

The progress notes were reviewed for resident #002. On a specified date after the drug was initially ordered, an entry indicated the resident was administered a dose of the drug at a specified time "with good effect", and a note entered later

by MD #104 indicated that the ordered drug had the desired effect on the resident. On a later specified date and at two specified times during a shift, RN #123 indicated in the progress notes that resident #002 was exhibiting signs and symptoms that were consistent with the indication for the ordered drug. There was no indication in the progress notes that the drug was administered as ordered. Review of the medication administration record and other specified records for resident #002 confirmed that the drug was not administered.

RN #123, Nurse Manager, was interviewed and confirmed that they were working on the specified shift, that resident #002 was exhibiting specified signs and symptom, and that they did not administer the drug as ordered. They indicated that they were the only RN for two units, responsible for approximately 57 residents, and that they likely did not administer the drug because they were too busy.

ADOC #103 was interviewed and acknowledged that the expectation was that drugs ordered to promote resident comfort while they were dying should be administered as ordered. The ADOC indicated that registered staff had attended their office soon after the HRH staff arrived at the home, and refused to administer certain specified drugs on the grounds that they were hastening resident death. They acknowledged that additional training in palliative care was required to ensure registered staff in the home would feel comfortable administering medications as ordered to promote resident comfort while they were dying.

These findings show that resident #002 did not receive end-of-life care when it was required in a manner that met their needs when they were not administered a specified drug as ordered during a specified shift. [s. 42.]

The severity of this issue was determined to be a level 3 as there was actual harm to resident #002. The scope of the issue was a level 1 as this issue was identified for one resident. The home had a level 2 compliance history as there were no prior non-compliances to this section of the legislation. (722)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 08, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Order / Ordre :

The licensee must be compliant with r. 229 (5) (b) of the Regulations.

Specifically, the licensee must ensure that, on every shift, symptoms associated with COVID-19 infection in all probable or confirmed cases of COVID-19 among residents in the home are recorded, and immediate action is taken, including notification of medical staff and family members, when there is a significant change in the resident's condition.

The home will conduct an audit to ensure that residents with COVID-19 infection are assessed each shift, and that appropriate actions were taken.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that, on every shift, symptoms indicating the presence of COVID-19 infection were recorded for resident #002 and that immediate action was taken as required.

A complaint was received by the MLTC related to overall care of residents in the home, and specifically involving resident #002.

In an interview, HRH MD #104 indicated that they attended rounds with staff in the home on a specified date and time and resident #002, who had a specified condition, was found with identified signs and symptoms that suggested a significant change in health status. The physician was concerned that the resident had not been assessed, appropriate care had not been provided during

the night shift or morning, and that medical personnel had not been notified of the resident's change in condition.

Review of resident #002's care plan indicated that the resident had a specified health condition, and that staff were expected to monitor and report mild to severe symptoms of the condition.

The vital signs and assessments were reviewed in the electronic health record, and there was no documentation which indicated that the resident's vital signs had been measured, or that the resident had been assessed for their change in condition.

Review of the progress notes indicated that resident #002 had a specified health condition, and that the resident was declining over several identified days; however, there were no assessment findings entered in the progress notes over this period, including documentation of vital signs, or any other signs or symptoms of the condition. On a specified date at two specified times, RPN #121 made two entries in the progress notes related to the resident; however, there was no indication in either of the progress notes about the resident's condition, their vital signs, that any actions had been taken, or that medical staff had been notified about the resident's change in condition. There were no further entries in the progress notes until the late morning the next day, when RPN #121 entered that they had done rounds with MD #104. They noted that at that time that resident #002 had specified signs and symptoms which indicated that the resident had a significant change in condition, and documented the action that was taken.

Further review of progress notes indicated that MD #104 made an entry which indicated that resident #002 was seen on rounds with the HRH Outreach Team and had a specified condition. MD #104 indicated that resident #002 had specified signs and symptoms that indicated a significant change in the resident's health status. They indicated in their note that they spoke with the resident's substitute decision maker (SDM) about the resident's condition and prognosis.

ADOC #103 was interviewed and confirmed that RPNs were expected to notify nurse managers and physicians when a resident's condition changed. The

ADOC acknowledged that there were no vital signs for the resident documented in a flow sheet outside of the electronic health record. They also acknowledged that the resident's status appeared to change significantly during the night shift and early day shift on the specified dates, the resident should have been assessed, and physician should have been notified. Inspector #722 made multiple attempts to contact RPN #121, who was responsible for resident #002's care on the specified dates, and they could not be reached.

Based on the evidence above, there was no indication that resident #002 had their symptoms of infection assessed on the specified dates, or that immediate action was taken as required due to the resident's significant change in condition. [s. 229. (5) (b)]

The severity of this issue was determined to be a level 3 because there was actual harm to a resident. The scope of the issue was a level 1 because the issue was identified in one resident. The home had a level 2 compliance history as there were no prior non-compliances issued to this section of the legislation. (722)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 08, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 4th day of June, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Corey Green

Service Area Office /
Bureau régional de services : Toronto Service Area Office