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
Jul 24, 2020	2020_816722_0010	009393-20	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)

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): Off-site: June 1-5, 8-12, and 15-16, 2020.

Complaint log #009393-20 related to COVID-19 testing was inspected during this inspection.

This inspection was conducted concurrently with Complaint Inspection #2020_816722_0008 and Critical Incident Inspection #2020_816722_0009.

PLEASE NOTE: Written Notifications and Compliance Orders related to LTCHA, 2007, c.8, s. 6(7) and s. 174.1(3) were identified in this inspection and have been issued in Inspection Report 2020_816722_0008, dated July 24, 2020, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector reviewed resident health records (electronic and paper copies); as well as relevant administrative records, including policies and procedures, and resident temperature logs.

During the course of the inspection, the inspector(s) spoke with the Acting Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), and the resident's family members.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Infection Prevention and Control

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. 229. Infection prevention and control program

Specifically failed to comply with the following:

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 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 infection in resident #008 were monitored in accordance with prevailing practices.

The Ministry of Long-Term Care (MLTC) received a complaint via the Action Line from resident #008's family member related to concerns that the resident was not tested for COVID-19 when they developed symptoms of infection.

On April 8, 2020, the Chief Medical Officer of Health (CMOH) issued Directive #3 for Long-Term Care Homes (LTCHs) under the Long-Term Care Homes Act,2007, which instructed LTCHs to conduct active screening of all residents, at least twice daily (at the beginning and end of the day) to identify if any resident has fever, cough or other symptoms of COVID-19.

Progress notes in PointClickCare (PCC) were reviewed for resident #008, which indicated the following:
- During a specified period (7 days, approximately 21 shifts), there were no entries in progress notes indicating any signs or symptoms of infection during this period.
- On a specified date, RN #127 entered a note which indicated that the resident had developed possible symptoms of infection and that a specified treatment was initiated.
- There were no other entries for any other shifts on the following two days.
- The next day, there was one entry by RPN #138 during the day shift where symptoms of possible infection were documented; no signs or symptoms of infection were documented in progress notes for the evening shift on this date.
- The resident was found without vital signs at a specified time the following day.

This review shows that, since the day shift on a specified date, when the resident developed possible symptoms of infection, there were at least six shifts when there was no documentation in the progress notes for resident #008 related to signs or symptoms of infection.

The Weights/Vital Signs tab in PCC was reviewed and indicated that resident #008's temperature was documented on a specified date several weeks earlier, and on one specified date several days before the resident's death; there were no other temperatures documented in PCC.

The Resident Temperature flow sheets for the resident home area where resident #008 resided were reviewed for several days prior to the resident's death. Resident #008's

temperatures were documented on each shift for each of these days; however, no other symptoms were documented for resident #008 in the space provided for “Comment / sign / symptoms” on the flow sheet on any of those days.

RPN #129 was interviewed and recalled working on the evening shifts on two specified dates just prior to the resident death, and being responsible for resident #008. They did not recall the resident's condition at the time of the interview, and thought that the resident may have already had a specified diagnosis. The RPN acknowledged that if the resident had refused to have vital signs taken, they would have documented that in the progress notes. They confirmed that the resident had a significant change in their status over two days, and if they had assessed the resident and identified any abnormal findings, they would have documented it and informed the physician. They also stated that this was a time when the home was very short-staffed, and they were the only registered staff working.

ADOC #103 confirmed during an interview that the expectation was that residents in the home were monitored for signs or symptoms of infection every shift. They acknowledged that typically staff only documented temperatures on each shift on the flow sheets, and that other signs and symptoms of infection were not captured there consistently. They also acknowledged that signs or symptoms of infection were not consistently monitored each shift for resident #008, and that they should have been. The ADOC stated that the signs or symptoms should have been documented on the available flow sheet on each unit, or in the resident’s progress notes in PCC.

The evidence above supported the finding that symptoms of infection in resident #008 were not monitored on every shift in accordance with prevailing practices as per Directive #3 for LTCHs. [s. 229. (5) (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 on every shift, 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, 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for resident #008 that set out clear directions to staff and others who provided direct care to the resident.

The Advanced Directive section of resident #008’s care plan was reviewed in PCC and specified actions that staff were required to take with a significant change in the resident's condition. There were no recent revisions to this section of the care plan.

Review of resident #008's Advance Directive form in the resident's chart indicated that soon after the resident was admitted to the home, substitute decision maker (SDM) #137 had consented to a specified directive that was consistent with the care plan as detailed above. There was an entry on the record by MD #147 with a specified date that indicated there was verbal consent to revise the resident’s Advanced Directive. It was not specified by MD #147 on the paper record, or in the progress notes, who provided verbal consent

for the change. The new directive did not match what was in the resident's care plan, and the care plan was not revised.

RPN #129 was interviewed and explained that they had provided resident #008 with care on two specified dates prior to their death. They acknowledged that the resident's condition had declined and that specified actions were not taken as per the resident's advanced directive (see finding under LTCHA, 2007, s. 6(7) in inspection report #2020_816722_0008). When asked about the resident's Advanced Directive, the RPN explained that they thought the resident was supposed to receive care as specified in the care plan, which they had looked up in the computer during the interview. They also acknowledged that they could look it up in the resident's paper chart at the nursing station, on the Advanced Directives form which would be in the front of the resident's chart.

RPN #127 indicated during an interview that they were certain that resident #008 was supposed to receive a specified level of care as indicated in their Advanced Directive, which was consistent with the care specified on the revised Advanced Directive form in the resident's chart. They indicated that they were certain the resident's family had changed the advanced directive recently; however, they acknowledged that it can be different between what is documented in the electronic care plan and the Advanced Directive form in the resident's chart, if it was not updated by registered staff.

ADOC #103 acknowledged in an interview that the Advanced Directives for resident #008 were different in the Advanced Directive form in the resident's chart, compared to the care plan in PCC. They acknowledged that the care plan should have been updated to match what was identified on the Advanced Directive form in the resident's chart to avoid confusion for staff.

The evidence above shows that the licensee failed to ensure that resident #008's written plan of care related to Advanced Directives set out clear directions to staff and others who provide direct care to the resident when the directive in the care plan differed from the directive in the Advanced Directive form in the resident's chart. [s. 6. (1) (c)]

Issued on this 5th day of August, 2020

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

Original report signed by the inspector.