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
Aug 14, 2020	2020_816722_0012	012032-20	Follow up

Licensee/Titulaire de permis

Gem Health Care Group Limited
15 Shoreham Lane, Suite 101 Halifax, NS UNKNOWN ON B3P 2R3

Long-Term Care Home/Foyer de soins de longue durée

Downsview Long Term Care Centre
3595 Keele Street NORTH YORK ON M3J 1M7

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

COREY GREEN (722)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): July 27-31, and August 4, 2020.

The following intake was completed during this Follow-up Inspection: Log #012032-20 related to safe and secure home.

During this inspection, observations were made of residents, resident home areas, and staff provision of care. Electronic health records and resident charts were reviewed. Various administrative records were reviewed, including policies and procedures, education materials, logs, and audits.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care (Acting DOC), the Environmental Services Manager (ESM), Resident Assessment Instrument (RAI) Coordinators, a Clinical Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Safe and Secure Home

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

- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 5.	CO #001	2020_816722_0007	722

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. (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 #020 related to advanced care directives that set out clear directions to staff and others who provided direct care to the resident.

During a follow-up inspection for compliance order #001 issued in Inspection Report #2020_816722_0007, advanced care directives for select residents were reviewed to determine compliance with the order.

During observations, it was identified that resident #020 had a care plan posted above their bed which indicated a specified level of care in the event that their condition changed.

Review of resident #020's care plan in the electronic health record, as well as the Advanced Directives form in the resident's chart, both specified a level of care that was different than the level of care posted on the care plan above the resident's bed. Both the care plan and Advanced Directive form in the chart had been revised since the care plan was originally posted above the resident's bed.

Review of the progress notes indicated that Social Worker (SW) #116 had spoken with resident #020's substitute decision maker (SDM), who provided verbal consent to change the level of care as reflected in the Advanced Directive form in the chart and care plan in the electronic health record.

During an interview, RPN #117 confirmed that the level of care specified in the care plan posted above resident #020's bed was inconsistent with the level specified in the resident's care plan in the electronic health record, as well as the Advanced Directive form in their chart. They acknowledged that, if the resident's condition had deteriorated, the staff may refer to the care plan posted in the resident's room and provide inappropriate care. They confirmed that the care plan posted above resident #020's bed should specify the level of care as indicated in the Advanced Directive form in the resident's chart, and the care plan in the electronic health record.

Acting DOC #103 confirmed in an interview that resident #020's plan of care was unclear when the level of care specified on the care plan posted above the resident's bed was different than the level of care specified on the Advanced Directive form in the resident's chart and the care plan in the electronic health record. [s. 6. (1) (c)]

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

During observations for a follow-up inspection, the inspector observed concerns with use of personal protective equipment (PPE) among staff for residents recently admitted to the home on droplet and contact precautions.

During observations in a specified resident home area (RHA), the inspector identified a specified number of resident rooms with “STOP” signs posted on doors, with a message to see the nurse prior to entering the room, and signs that indicated droplet and contact precautions were required. In separate interviews with Acting DOC #103 and RPN #124, they confirmed that these signs were posted on resident room doors for those who were recently admitted to the home and were being placed on 14-day isolation precautions pending results from their post-admission COVID-19 test.

On a specified date and time, resident #021 was observed sitting in their wheelchair in the hallway outside their room without a mask or any other PPE. The sign on the door to their room indicated that droplet and contact precautions were required. PSW #122 was observed wearing a face mask and shield, donned gloves, and entered resident #021's

room to change the linens on the bed; they did not don a gown, or perform hand hygiene prior to donning gloves. The PSW exited the room, doffed gloves, and did not perform hand hygiene. The PSW proceeded to touch resident #021 on the arm without gloves in the hallway, and then wheeled the resident into their room, again without hand hygiene or donning gown or gloves. PSW #122 was also observed entering another room without donning a gown or performing hand hygiene, where a sign on the door indicated that droplet and contact precautions were required.

PSW #122 confirmed in an interview that resident rooms with the droplet and contact precaution signs indicated that a mask, goggles, gown and gloves were required. However, they indicated that the precautions were no longer required for these residents because the they had tested negative for COVID-19 and were there from before, “when the COVID was here.” They also stated that registered staff usually informed them during shift report if additional precautions were required for residents and indicated that they were not informed this was the case on shift report.

On another specified date and time, PSW #123 was observed entering resident #022's room, which also had a STOP sign and signs indicating droplet and contact precautions were required. PSW #123 was wearing a mask and face shield, donned gloves and entered the room; they did not perform hand hygiene or don a gown.

PSW #123 indicated during an interview that they provided direct care to resident #022 and had direct contact with the resident. They confirmed that they did not perform hand hygiene or don a gown. They indicated they were aware resident #022 was a new admission, was on isolation precautions, and acknowledged that they should have performed hand hygiene and put on a gown for direct care.

On another specified date and time, PSW #125 was observed pushing resident #023 down the hallway and into their room, which had a STOP sign and droplet and contact precautions signs on the door. PSW #125 was wearing a mask and face shield; however, they were not wearing gown or gloves. When PSW #125 entered the room with the resident, another staff person was also observed in the room; they were wearing a mask and face shield, and no gown or gloves, while they changed linens on the resident’s bed. PSW #125 was observed placing their hand (without gloves) on the resident’s shoulder prior to leaving the room; however, they performed hand hygiene in the washroom prior to leaving the resident's room.

PSW #125 indicated during an interview that they were returning resident #023 to their

room from another area of the home. The PSW was aware that the signs on the resident's door indicated that they were on droplet and contact precautions, but they stated that the resident was not on droplet and contact precautions. They were not aware why the sign was posted on the resident's door, and confirmed that they wore a mask and face shield while transporting the resident from the other area of the home and did not don a gown or gloves.

Acting DOC #103 confirmed during an interview that staff were expected to use droplet and contact precautions when providing direct care to residents who were recently admitted to the home on isolation, pending results from the in-home COVID-19 test. They explained that based on the point-of-care risk assessment, a gown and gloves may not always be required; however, they confirmed that in the situations described above, gowns, gloves and appropriate hand hygiene were required. The DOC also confirmed that residents on isolation precautions should not be sitting in the hallway; and indicated that staff transporting residents in the home on droplet and contact precautions should always wear gowns, gloves, masks and face shields.

The Acting DOC acknowledged that in the situations described above, staff did not participate in the implementation of the IPAC program in the home. [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

Issued on this 18th day of August, 2020

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

Original report signed by the inspector.