Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
Telephone: 1-866-311-8002
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Original Public Report

Report Issue Date September 15, 2022
Inspection Number 2022_1027_0003
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Gem Health Care Group Limited

Long-Term Care Home and City
Downsview Long-Term Care Centre, North York

Lead Inspector
April Chan (704759)

Additional Inspector(s)
Fiona Wong (740849)

Inspector Digital Signature
April W Chan
Digitally signed by April W Chan
Date: 2022.10.17 11:05:36 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 26, 29-31, September 1 and 6, 2022

The following intake(s) were inspected:

- #000985-22 (CIS) related to resident with injury of unknown cause
- #013860-22 (Complaint) related to multiple care concerns

The following **Inspection Protocols** were used during this inspection:

- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Resident Care and Support Services

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

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NC#01 remedied pursuant to FLTCA, 2021, s. 154(2)

Non-compliance with: O. Reg. 246/22, s.102 (7) 11

The licensee failed to ensure that there was in place a hand hygiene program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard). Specifically, the IPAC lead failed to ensure that the hand hygiene program included access to 70-90% Alcohol Based Hand Rub (ABHR) as was required by Additional Requirement 10.1 under the IPAC Standard. The IPAC lead failed to remove expired ABHR that was in use in the home.

On August 26, 2022, Inspector #740849 and Inspector #704759 observed expired hand sanitizers located in two resident home areas and one dining room. The home indicated that hand sanitizer potency would be reduced when expired, as such the alcohol content of at least 70% would not be maintained.

The home removed expired hand sanitizers on August 26, 2022. Expired hand sanitizers were no longer observed during the remainder of the inspection. Director of Care (DOC) and Environmental Manager stated that there was low risk to residents as most staff and residents used the hand sanitizers from dispensers mounted on the walls that were not expired.

Sources: interviews with DOC and Environmental Manager, observations from Inspector #740849 and Inspector #704759.

Date Remedy Implemented: August 26, 2022 [740849]

WRITTEN NOTIFICATION TRANSFERRING AND POSITIONING TECHNIQUES

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 *s.36*

The licensee has failed to ensure that two personal support workers (PSWs) used safe transferring technique when transferring a resident.

Rationale and Summary

The resident required assistance from two staff using a mechanical lift to transfer. On a specific date, the resident was transferred manually by two PSWs from chair to bed. During the transfer process, the resident sustained an injury. Staff members and DOC stated that the resident should have been transferred using a mechanical lift. The resident was harmed by unsafe transferring.

Sources: Critical Incident System (CIS) report, the Home's Investigation Summary, the resident's care plan, interviews with staff members and DOC.

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WRITTEN NOTIFICATION PLAN OF CARE

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 *s. 6 (1) (c)*

(i) The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided medication therapy to the resident.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 6 of LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 6 (1) (c) of O. Reg. 246/22 under the FLTCA.

Rationale and Summary
A complaint was received by the Ministry of Long-Term Care (MLTC) regarding multiple care concerns including medication administration.

The home's medication policy indicated that all medication orders must be communicated with the pharmacy and that best practice would recognize a discontinuation of an order would include a new entry with clear directions of the new order.

The resident received a new prescriber order on a specific date in the morning to start a medication. The power of attorney (POA) was informed the same day and requested a trial of the therapy for one week, and to be reassessed. The resident's new medication was to be discontinued after seven days. The resident was administered the medication for the seven days, and then approximately for another two months and twenty days.

A registered nurse (RN) indicated that the plan to trial the medication was written on the resident's medication administration record (MAR) on the starting month, however a new follow-up order to indicate a one-week trial should have been written in the digital orders but was missed. Medication administration continued in the next month per prescriber's order from the initial order date and not per instructions on the starting month's MAR.

There was minimal risk to the resident when they continued to receive the medication as ordered by the home's physician.

Sources: the home's policy on Medication Administration Record Checking / Updating – Paper MAR, the resident's clinical records, interviews with complainant, staff and DOC.

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(ii) The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care including assistance with drinking.

Rationale and Summary
The resident's written plan of care indicated they required pudding thick fluids for meals. During the inspection, a sign was observed in the resident's room dated a specific date, which indicated the resident was on honey thick fluids.

An RN indicated that the sign posted in the resident's room should be removed as it was outdated and incorrect. A registered practical nurse (RPN) agreed that the resident's posted sign should be clarified but the sign was not removed. The home indicated that the interdisciplinary team including registered staff and manager were responsible to update the posted signs in the resident's room.

There was minimal risk of harm to the resident because food services produced and delivered pudding thick fluids as required for the resident's meals.

Sources: the resident's plan of care, observations, interviews with staff, and DOC.

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(iii) The licensee has failed to ensure that the written plan of care for a resident #002 and resident #005 set out clear directions to staff and others who provided assistance with oral care.

Rationale and Summary
Resident #005 was observed to be assisted with oral care by an RPN using a toothbrush soaked in specific solution.

A PSW identified that resident #005 received oral care from PSWs using a specific oral care supply only and that toothbrushing was not appropriate. Two staff members identified that the resident was unable to use a specific solution to rinse and that they required a toothbrush dipped in a specific solution to be brushed by registered staff. DOC indicated that toothbrushing with toothpaste may not be appropriate for the resident.

Resident #005's plan of care did not specify how to perform oral care with a specific oral care supply or toothbrush.

Two PSWs identified oral care for resident #002 required the specific oral care supply and that a regular toothbrush could not be used due to safety. An RN expected oral care for the resident to include use of both the specific oral care supply and regular toothbrushing. DOC identified that resident #002 could tolerate toothbrushing with a small amount of toothpaste.

Resident #002's written plan of care did not specify direction on performing oral care using both the specific oral care supply and regular toothbrushing.

Registered staff and DOC acknowledged that the written plan of care for oral care should be revised to clarify how oral care should be performed for resident #002 and resident #005.

There was minimal risk of harm to the residents when clear directions were not set out on how to perform oral care.

Sources: resident #002's and resident #005's plan of care, observations, interviews with DOC and other staff.

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WRITTEN NOTIFICATION PLAN OF CARE

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 *s. 6 (4) (a)*

The licensee has failed to ensure that the staff and others involved in difference aspects of care of a resident collaborated with others in the assessment of the resident during mealtime so that their assessments were integrated.

Rationale and Summary
The home's Registered Dietitian Referral policy indicated that the registered staff shall inform the Registered Dietitian (RD) nutrition and hydration risks such as chewing or swallowing concerns. Registered staff identified that an RD referral should be sent the same day when chewing or swallowing concerns are identified for any resident.

On specific date, the resident was noted to be coughing during their meal and unable to eat. They were given modified texture diet that was then tolerated well. The next day, the resident was noted as unable to tolerate their meal and was given again the modified texture diet which was tolerated without coughing. There was no new referral to the RD for the swallowing concerns on the two dates.

The resident was assessed by RD on the day after the incidents, for other reasons. The RD did not receive a new referral on the specified dates and had expected to receive a new RD referral from registered staff. There was moderate risk of harm to the resident identified when an RD referral was not sent for coughing during meals.

Sources: the home's policy on Registered Dietitian Referral Policy, the resident's clinical records, interviews with RD, DOC and other staff.

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WRITTEN NOTIFICATION NURSING AND PERSONAL SUPPORT SERVICES

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 *s. 39 (1)*

The licensee has failed to ensure that a resident received preventative and basic foot care services, including the cutting of toenails to ensure comfort and prevention infection.

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Rationale and Summary

The home's policy on Personal Hygiene stated that each resident will receive personal care daily which includes toenail care. The PSWs were responsible to provide nail and foot care excluding residents with specific medical conditions.

The resident was not diagnosed with specific medical condition excluding them from receiving nail and foot care. Two PSWs stated that toenail trimming for the resident was the responsibility of a foot care professional and not of PSWs. Registered staff and DOC indicated that nail care, including trimming toenails, was the responsibility of PSWs and was to be done.

DOC identified that the home was conducting audits on nail care for residents in the home. There was minimal risk of harm identified to the resident as toenail trimming was done by their caregiver and was not done by PSWs.

Sources: the home's policy on Personal Hygiene, interviews with DOC and other staff.

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