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
Dec 15, 2020	2020_526645_0009	005145-20	Follow up

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

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

Westside
1145 Albion Road Etobicoke ON M9V 4J7

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

DEREGE GEDA (645)

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): December 1, 2, 3 and 4, 2020.

This inspection was completed to inspect upon a follow up intake log #005145-20.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Directors of Care (ADOC), Infection Prevention and Control (IPAC) coordinator, Physiotherapy Assistant (PTA), Environmental Services Supervisor (ESS), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspector observed the provision of care, services and supplies; reviewed records including but not limited to relevant training records, policies and procedures, line listings, residents' clinical health records, and staff schedules.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services

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

- **1 WN(s)**
- **1 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
O.Reg 79/10 s. 36.	CO #001	2020_769646_0005	645

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. (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 the inspection, Inspector #645 observed a resident sitting in the common lounge area. A few minutes later, the resident was observed wandering in the hallway and attempting to enter a room that had a COVID-19 positive sign displayed on the door. There were no staff members observed within proximity monitoring the resident. Inspector stopped the resident from entering the room and called PSW #103. The PSW indicated that the resident wanders out of their room frequently and had a one to one PSW assigned to monitor them for the past few days, but they were not sure who was monitoring them on that day. Interview with another PSW #104 indicated that there was no one to one PSW assigned for the resident and they were not sure who was monitoring the resident.

Interviews with the IPAC coordinator and ED indicated that all wandering residents have one to one PSW assigned to prevent wandering in the hallway and other residents' room. They indicated that residents are not allowed to wander or use the common areas due to infection control risk. The ED indicated that the resident was supposed to have a one to one PSW, but they were not sure how no one was assigned on that day and promised to get a staff assigned as soon as possible.

Sources: observations, resident's plan of care and progress notes, staff Schedule records and interviews.

2. On another day, Inspector #645 observed a PTA providing care for resident #002, who was on a droplet/contact isolation precaution. The PTA was observed providing care and setting the resident up for their lunch in their room without donning the appropriate personal protective equipment (PPE). Inspector observed a droplet/contact signage posted on the resident's room door, that directed staff members to wear mask, face-shield, gowns and gloves prior to entering the room. The PTA confirmed that they did not wear the appropriate PPE prior to entering the resident room, and indicated that they

normally wear PPE when they provide care for residents.

During the course of inspection, Inspector #645 observed an RPN administering medication for resident #003, who was on a droplet/contact isolation precaution. The signage posted on the resident's door directed staff members to wash hands, wear mask, face-shield, gowns and gloves. The RPN was observed not wearing gloves and gowns when administering medications. The RPN apologized and indicated that the expectation was to wear all the necessary PPEs prior to entering the resident room.

Inspector #645 also observed a PSW providing a lunch tray and assisting resident #004 to sit in their chair located in their room, without wearing gloves and gown. The resident was on droplet/contact isolation precaution, and the signage was posted on the resident's door. The PSW indicated that the resident was wandering in the hallway and they had to bring them back to their room to assist them with lunch. The PSW reiterated that the expectation was to wear all the necessary PPEs prior to entering the resident room.

Interviews with the IPAC coordinator and ED indicated that the home was in COVID-19 outbreak and all residents were placed under droplet/contact isolation precautions. The ED indicated that it was the expectation of the home that staff members wear the appropriate PPE to prevent COVID-19 infection transmission. The IPAC coordinator indicated that they will educate staff members and reiterate the necessity of complying with the home's infection prevention and control practices.

Sources: observations, residents #002, #003 and #004's plan of care, and interviews. [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 participated in the implementation of the infection prevention and control program, to be implemented voluntarily.

Issued on this 23rd day of December, 2020

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

Original report signed by the inspector.