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
TorontoSAO.moh@ontario.ca

Original Public Report

Report Issue Date July 15, 2022
Inspection Number 2022_1027_0002
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
15 Shoreham Lane, Suite 101 Halifax NS B3P 2R3

Long-Term Care Home and City
Downsview Long Term Care Centre
3595 Keele Street North York ON M3J 1M7

Lead Inspector
Nicole Ranger (189)

Inspector Digital Signature
Nicole S Ranger
Digitally signed by Nicole S Ranger
Date: 2022.07.26 09:56:25 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 27, 28, 29, 30, July 4, 7, 8, 2022.

The following intake(s) were inspected:

- Log # 000455-21 (CIS # 1041-000002-21), and # 012113-21 (CIS # 1041-000013-21) related to Falls Prevention and Management.
- Log # 012906-21 (CIS # 1041-000014-21), and # 000039-22 (CIS # 1041-000001-22) related to Prevention of Abuse and Neglect, Responsive Behaviours.
- Log # 009800-22 (Follow-up) related to Infection Prevention and Control.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 246/22	s. 102 (2) b	2022_1027_0001	001	Nicole Ranger (189)

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
TorontoSAO.moh@ontario.ca

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION TRANSFERRING AND POSITIONING

NC#001 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 staff used safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary

Resident #001 was found with a skin impairment to an identified area. An x-ray was taken which revealed an injury to the identified area. Personal Support Worker (PSW) #102 informed Director of Care (DOC) #103, that they had transferred the resident using a mechanical lift, without a second person assisting.

PSW #102 confirmed that two persons assist are always required for use of the mechanical lift.

Failure to provide two person assistance to resident #001 for transferring placed them at risk of injury.

Sources: Resident #001's written plan of care, progress notes, homes investigation notes, CIS report # 1041-000002-21, interviews with PSW #102, Director of Care #101
[189]

WRITTEN NOTIFICATION RESPONSIVE BEHAVIOURS

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 54(b)

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

Rationale and Summary

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
TorontoSAO.moh@ontario.ca

Resident #003 and Resident #004 had a history of verbal and physical altercations over the course of approximately eight months.

In August 2021, resident #004 was assessed by the psycho-geriatrian, who indicated the altercations were triggered by resident #003 and suggested transferring one of the residents to separate them. This assessment was reviewed by Behavioural Support Ontario Lead (BSO) #104, however, no action was taken to move either resident.

In January 2022, resident #003 struck resident #004. Resident #004 sustained injuries because of the altercation. Resident #003 was transferred to another unit in April 2022. Staff reported that since resident #003 was moved, resident #004's behavior has improved.

DOC #101 acknowledged that the suggestion of transferring one resident to another unit in August 2021 should have been implemented.

Failure to implement the suggestion of transferring one resident to separate them in August 2021, increased the risk of additional altercations between the residents.

Sources: Resident #003 and #004 's progress notes, CIS report # 1041-000014-21, CIS report # 1041-000001-22, interviews with PSW #104, PSW #109, RPN #105, RPN #110, RPN #111, DOC #101, BSO Lead #104.

[189]