Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: February 24, 2023	
Inspection Number: 2023-1027-0004	
Inspection Type: Critical Incident System	
Licensee: Gem Health Care Group Limited	
Long Term Care Home and City: Downsview Long Term Care Centre, North York	
Lead Inspector Reji Sivamangalam (739633)	**Inspector Digital Signature** Reji K Sivamangalam Digitally signed by Reji K Sivamangalam Date: 2023.03.08 10:09:01 -05'00'
Additional Inspector(s) Inspector Dorothy Afriyie (000709) was present during the inspection.	

INSPECTION SUMMARY

The inspection occurred on the following date(s): February 2-3, 6-10, 2023

The following intake(s) were inspected:
-Intake #00014766 [Critical Incident System (CIS) #1041-000016-22] related to injury due to unknown reason
-Intake #00016829 (CIS #1041-000018-22) related to falls prevention and management

The following intake(s) were completed:
-Intakes #00004599 (CIS #1041-000008-22) and #00013062 (CIS #1041-000011-22) were related to falls prevention and management.

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

Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: REQUIRED PROGRAMS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 53 (1) 1.

The licensee has failed to ensure that the falls prevention and management program was implemented when a fall risk assessment was not completed upon a resident's return from hospital.

In accordance with O. Reg. 246/22 s 11 (1) (b), the licensee is required to ensure that a fall risk assessment is completed within twenty four hours of readmission from hospital or Emergency Room (ER) visit. Specifically, staff did not comply with home's policies "Fall Prevention and Management Program"

Rationale and Summary

(i) A resident sustained an injury and was transferred to ER and re-admitted to the home on the same day. The Clinical Nurse Manager, the home's fall prevention and management program lead, verified that staff were expected to complete a fall risk assessment per the home's Fall Prevention and Management Program policy and a fall risk assessment was not completed upon the resident's re-admission after the ER visit.

The resident was at risk when their risks of falls were not identified.

Sources: The home's Fall Prevention and Management Program, the resident's progress notes and assessments, and interview with Clinical Nurse Manager

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The licensee has failed to ensure that the falls prevention and management program was implemented when Head Injury Routine (HIR) was not initiated after a resident's fall.

In accordance with O. Reg. 246/22 s 11 (1) (b), the licensee is required to ensure that HIR was initiated

for all unwitnessed falls. Specifically, staff did not comply with home's policies "Fall Prevention and Management Program".

Rationale and Summary

(i) A resident had an unwitnessed fall. Post fall assessment indicated that HIR was not initiated after the fall. The Clinical Nurse Manager, the home's fall prevention and management program lead, verified that staff were expected to initiate HIR per the home's Fall Prevention and Management Program policy.

When HIR was not initiated after the unwitnessed fall, the resident was at risk of a head injury not being detected.

Sources: The home's Fall Prevention and Management Program, the resident 's progress notes and assessments, and interview with Clinical Nurse Manager.

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WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 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 collaborated with each other in the assessment of a resident’s medications related to fall risk.

Rationale and Summary

The resident was at high risk of falls and sustained multiple falls. The psycho-geriatrician was involved in the resident's care. The pharmacist recommended re-evaluating the resident's medications if falls persisted. The resident had a fall on a later date. Clinical Nurse Manager and Director of Care stated that the pharmacist's recommendation was expected to be followed up by the resident's primary physician and a referral be made to the psycho-geriatrician for the medication review and Behavioral Supports Ontario (BSO) Lead coordinates the referral process.

The Behavioral Supports Ontario (BSO) Lead and DOC verified that a re-evaluation of the resident's medications was not completed related to the fall risk based on the pharmacist's

recommendations.

There was a risk to resident when their medications were not re-evaluated.

Sources: Resident's progress notes and assessments, the home's Fall Prevention and Management Program, interview with Clinical Nurse Manager BSO Lead and DOC.

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WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 58 (4) (b)

The licensee has failed to ensure that strategies were developed to prevent and respond to a resident's responsive behaviours.

Rationale and Summary

The resident was admitted to the home and exhibited responsive behaviours after admission. The resident sustained an injury during the episode, was transferred to the hospital and was re-admitted to the home on the same day. Behavioral Supports Ontario (BSO) Lead verified that no strategies and interventions were developed to prevent and manage further episodes of responsive behaviours upon the resident's return from the hospital.

The BSO Lead acknowledged that the resident was at risk of reoccurrence and escalation of responsive behaviours when strategies were not developed.

Sources: The resident's clinical records, and interview with BSO Lead.

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COMPLIANCE ORDER CO #001 INFECTION PREVENTION AND CONTROL

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1) Conduct random audits for three weeks to ensure staff assist residents of a specific home area with hand hygiene before meals.

2) Conduct random audits for three weeks in a specific home area in all shifts to ensure staff members wear appropriate Personal Protective equipment's (PPE) when required.

3) Maintain a documented record of the aforementioned audits, including the responsible person, date, time, outcome and any actions taken.

4) Develop and implement written procedures to ensure all staff members receive appropriate N95 masks according to their fit test results before beginning work when required.

Grounds
The licensee has failed to ensure that staff provided support for residents to perform hand hygiene prior to receiving meals as required by Additional Requirement, specifically 10.4 (h), under the Infection Prevention and Control (IPAC) standard.

Rationale and Summary

(i) A home area was on infectious disease outbreak, and meals were served in residents' rooms. It was observed that five residents were not assisted with hand hygiene prior to receiving lunch in their room. The staff member acknowledged that they did not provide hand hygiene assistance to the residents before serving the lunch. The IPAC Lead verified that staff were expected to provide hand hygiene assistance to residents before the meal.

Failure to support residents with hand hygiene increased the risk of infection transmission.

Sources: Observations, interview with staff member and IPAC Lead

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The licensee has failed to ensure that staff used appropriate personal protective equipment (PPE). Specifically, staff did not don required Personal Protective Equipment's (PPE) when working in a home area which was on infectious disease outbreak as per 9.1 (d) under the IPAC standard.

Rationale and Summary

(ii) A home area was on infectious disease outbreak, and all staff members were required to don N95 and eye protection inside the unit. A staff member was observed to be inside a resident's room doing documentation wearing only a face shield. The staff member acknowledged that they were expected to wear an N95 mask and face shield inside the unit. IPAC Manager verified that the staff members were expected to don N95 masks and face shields when entering and inside the unit.

There was a risk of infection transmission when the staff member did not wear the required PPE in outbreak units.

Sources: Observations, The home's Routine Practices and Additional Precautions policy, interview with staff member and IPAC Lead

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The licensee has failed to ensure that the staff members got the N95 masks according to their fit-testing results. Specifically, there was no system in place for having a PPE supply and stewardship plan to ensure adequate access to PPE for Routine practices and Additional Precautions as required by Additional Requirement 6.1 under the IPAC standard.

Rationale and Summary

(iii) A home area was on infectious disease outbreak and staff members were required to wear N95 masks inside the unit. A staff member was observed in the nursing station wearing an N95 mask that did not cover their nostrils and did not fit appropriately on the face. The staff member stated that they had picked up the mask from the screening station and were not aware of the specifications of the N95 mask according to the mask fit-testing. Another staff member, who was working on a different date, for the evening shift in the same home area stated that they took the mask from the screening station and did not know their N95 mask type according to the mask fit testing. On the same day another staff member

was observed wearing an N95 mask, and the specifications of their mask were different from the list of mask fit tests of the staff members. The staff member who was managing the screening station, stated that they did not carry a list of mask tests for the staff members, and staff members were choosing the masks from the screening station according to their comfort.

The Environmental Services Manager (ESM) verified that the home did not have a process to ensure the staff members received the N95 masks according to their mask fit tests.

There was an increased risk of infection transmission when the staff wore improper masks.

Sources: Observations, The home's Personal Protective Equipment Management Process Policy & Procedure, interviews with staff members and ESM.

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This order must be complied with by April 13, 2023

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Compliance Order #001, 2022_1027_0001, O. Reg. 246/22, s. 102 (2) (b)

This is the first time the licensee has failed to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.