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: October 18, 2023	
Inspection Number: 2023-1027-0006	
Inspection Type: Critical Incident	
Licensee: Gem Health Care Group Limited	
Long Term Care Home and City: Downsview Long Term Care Centre, North York	
Lead Inspector Ann McGregor (000704)	**Inspector Digital Signature** Ann McGregor Digitally signed by Ann McGregor Date: 2023.10.19 15:45:12 -04'00'
Additional Inspector(s) Chinonye Nwankpa (000715) Wing-Yee Sun (708239) was also present.	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 4-6 and 10, 2023. The following intake(s) were inspected:

- Intake: #00088763 - Critical Incident (CI) #1041-000008-23 - Fall of resident resulting in injury.
- Intake: #00090028 - CI #1041-000009-23 - Fall of resident resulting in injury.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when their care needs changed.

Rationale and Summary
A resident sustained multiple falls which resulted in an injury and subsequently passed away.

The resident's clinical records identified factors that have contributed to the falls. A Personal Support Worker (PSW) and Registered Nurse (RN) verified that the resident exhibited the identified contributing factors prior to the fall incident. The resident's care plan had not been revised to reflect the changes identified.

The RN, Falls Lead and the Nurse Manager relayed that, preceding the fall, the resident's care needs changed as they exhibited increased responsive behaviours and required more assistance. The RN and Nurse Manager verified that the changes were not revised in the resident's care plan.

Failing to revise the care plan when the resident's care needs changed increased the risk of staff not providing them with the appropriate assistance or interventions, which also increased their risk of falling and injury.

Sources: Resident's clinical records, resident's care plan; interviews with PSW, RN, Falls Lead, Nurse Manager, and other staff. [000715]