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: November 22, 2023.	
Inspection Number: 2023-1027-0007	
Inspection Type: Complaint Critical Incident	
Licensee: Gem Health Care Group Limited	
Long Term Care Home and City: Downsview Long Term Care Centre, North York	
Lead Inspector Trudy Rojas-Silva (000759)	**Inspector Digital Signature** Trudy Rojas-Silva Digitally signed by Trudy Rojas-Silva Date: 2023.12.07 10:08:02 -05'00'
Additional Inspector(s) Nicole Ranger (189)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 31, 2023, November 1-3, and 6-7, 2023.

The following intake(s) were inspected:

- Complaint intake #00098552 and Critical Incident (CI) intake #00098040 CI #1041-000015-23 were related to skin and wound prevention and management.
- Intakes #00095175 CI #1041-000011-23 and #00096101 CI #1041-000012-23 were related to fall prevention and management.
- Intake #00099946 CI #1041-000017-23 was related to the prevention of abuse and neglect.

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
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 (4) (a)

The licensee has failed to ensure that staff and others involved in different aspects of the residents skin and wound care, collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other

Rationale and Summary

The resident's Substitute Decision Maker (SDM) reported that upon hospital admission, there was redness and discoloration to a resident's specific skin area.

Staff confirmed that the resident had redness to the specific area, however no documentation of the redness to the specific area was identified.

The Physician stated that they were not informed of the redness to the specific area, and typically they would prescribe a different medication for the redness to the specific area.

The Clinical Nurse Manager (CNM) reported that they received concerns from the resident's

family member that there was redness to the resident's specific area, but confirmed there was no documentation of the redness to the specific area.

The Director of Nursing (DON) acknowledged that the Physician should be notified when an area of redness is noted so an assessment could have been conducted, and treatment interventions applied.

The staff's failure to collaborate with the Physician on the skin impairment for the resident may have prevented the timely implementation of treatment intervention to promote wound healing.

Sources: Resident clinical records, and interviews with RPN and other relevant staff.
[189]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Licensee failed to immediately report to the Director abuse of a resident by a resident that resulted in harm to the resident.

Rationale and Summary

A physical altercation occurred between residents, resulting in one of the residents falling and sustaining an injury.

The incident is classified as resident-to-resident abuse and the home did not report it to the Director on time.

Failure to immediately report the incident of resident to resident abuse to the Director did not place the resident at risk.

Sources: Interview with DON, CI #1041-000017-23.
[000759]

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) (a)

The licensee failed to ensure that for the resident, who demonstrated responsive behaviours, behavioural triggers were identified, where possible.

Rationale and Summary

A resident exhibited responsive behaviors towards another resident, which led to a physical altercation that resulted in an injury to one of the residents.

This resident had a history of responsive behaviors towards other residents that had led to physical altercations.

Staff members verified that they were unaware of this resident's history of displaying responsive behaviors, nor where they aware of this residents behavioral triggers.

Behavioral Support Ontario (BSO) leads and review of this resident's plan of care verified there were no behavioral triggers identified that would help staff prevent or minimize the occurrence of responsive behaviors.

Failure to identify the resident's behavioral triggers placed other residents at risk for harm and injury as a result of ineffectively managed responsive behaviors.

Sources: Resident's plan of care, Interviews with BSO leads and other relevant staff.
[000759]

COMPLIANCE ORDER CO #001 Duty to Protect

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

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

(i) Provide re-education to PSW #100 on the home's policy to promote zero tolerance of abuse and neglect of residents; document the education, including the date, the staff who were educated and the staff member who provided the education.

Grounds
The licensee has failed to protect a resident from abuse by another resident.

Rationale and Summary

A staff member witnessed a resident exhibited responsive behaviors that led to an altercation in the dining room with another resident which resulted in the other resident sustaining an injury.

Interview with the DON verified that it was the expectation that staff members intervened and deescalated the incident when they witnessed the incident between the residents before it escalated to a physical altercation.

Failure to intervene during an altercation between two residents caused a resident to fall and sustain an injury.

Sources: Video footage of incident, Interview with PSW and other relevant staff.
[000759]

This order must be complied with by December 7, 2023

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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:

CO #001 issued under the LTCA, 2007, for inspection #2021_526645_0025, issued on October 21, 2021.

This is the first AMP that has been issued to the licensee for failing 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

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.