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
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Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: January 16, 2024

Inspection Number: 2023-1027-0008

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Gem Health Care Group Limited

Long Term Care Home and City: Downsview Long Term Care Centre, North York

Lead Inspector	**Inspector Digital Signature**
Cindy Ma (000711)	Shuang Yu Ma Digitally signed by Shuang Yu Ma Date: 2024.01.19 10:08:48 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred on the following date(s): January 3-5, 8-11, 2024.

The following intake(s) were inspected:
- Intake: #00101318 - [CI: 1041-000018-23] -resident to resident physical abuse
- Intake: #00100745 - Complaint related to air temperature in areas of the home, temperature of the hot water, dealing with complaints, recreational and social activities, food and fluids being served, communication methods and care and services.
- Intake: #00102424 - Follow-up to Compliance Order #001 from inspection # 2023-1027-0007 – Duty to protect

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1027-0007 related to FLTCA, 2021, s. 24 (1) inspected by Cindy Ma (000711)

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Recreational and Social Activities

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 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that the planned care for a resident was set out to

include a behaviour management intervention.

Rationale and Summary
A resident was ordered to receive a specific behaviour management intervention. In speaking with the Behavior Support Ontario (BSO) Lead, they confirmed that the resident has been receiving that specific intervention on an ongoing basis since a specified day.

Review of the resident's care plan did not note the specific intervention as part of their behaviour management interventions.

The BSO Lead and Director of Care (DOC) stated that the resident's care plan should have included the specific intervention as part of the resident's behaviour management interventions.

Failure to include the intervention in the resident's plan of care placed them at risk of not receiving care in accordance with their assessed needs.

Sources: Resident's care plans; interviews with staff
[000711]

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Ontario Regulation (O. Reg.) 246/22 s. 2 (1), defines "physical abuse" as the use of physical force by a resident that causes physical injury to another resident.

The licensee has failed to ensure that a resident was protected from physical abuse.

Rationale and Summary
A Critical incident (CI) was reported to the Director on November 7, 2023, related to an incident of resident-to-resident physical abuse.

A Personal Support Worker (PSW) stated they witnessed a resident striking another resident on the face. As a result, one of the residents sustained an injury. This was confirmed by a Registered Nurse (RN) and Clinical Nurse Manager (CNM).

The DOC verified the above mentioned incident constituted physical abuse.

There was physical impact to the resident when they were physically abused by the other resident.

Sources: Critical incident report #1041-000018-23; and interviews with staff [000711]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to report the physical abuse of a resident by another resident to the Director immediately after it occurred.

Rationale and Summary
On a specified day, an RN responded to an incident related to resident-to-resident physical abuse. The CNM and DOC verified an incident of resident-to-resident physical abuse on that specified day.

The incident was not reported to the Infoline-LTC Homes after hours. The home submitted a Critical Incident System (CIS) report about the incident the following day.

The RN, CNM and the DOC acknowledged that the incident was not reported to the Director immediately after it occurred, as required.

Sources: Critical incident report #1041-000018-23; and interviews with staff [000711]