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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Original Public Report

Report Issue Date: August 02, 2024

Inspection Number: 2024-1027-0001

Inspection Type:
Proactive Compliance Inspection

Licensee: Gem Health Care Group Limited

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

Lead Inspector	**Inspector Digital Signature**
Reji Sivamangalam (739633)	Reji K Sivamangalam Digitally signed by Reji K Sivamangalam Date: 2024.08.07 13:48:56 -04'00'

Additional Inspector(s)
Parimah Oormazdi (741672)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 5, 6, 10 - 14, 17 and 20, 2024

The following intake(s) were inspected:

- Intake: #00115159 - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Residents' and Family Councils

Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
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 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that fall prevention interventions for a resident were provided to the resident as specified in the plan of care.

Rationale and Summary:

1) The resident's written plan of care specified that the resident required specific interventions for preventing falls. On a specific date the resident was observed without these interventions in place.

The staff members acknowledged that the resident's plan of care was not followed per observation.

The resident was at risk of falls and injuries when the required interventions were not provided.

Sources: Observations, resident's written plan of care, and interviews with staff members.

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The licensee failed to ensure that a resident was provided with required level of assistance for their care as specified in the plan of care.

Rationale and Summary:

2) The resident required a specific level of assistance for their care. Staff members acknowledged that the required assistance was not provided to the resident for their care on a specific date and stated that the resident's plan of care was not followed.

Failure to provide the required assistance for care increases the residents' risk of sustaining an injury and may impact the quality of care.

Sources: Observations, resident's written plan of care, interviews with staff members.

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WRITTEN NOTIFICATION: QUALITY

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (1)
Resident and Family/Caregiver Experience Survey
s. 43 (1) Every licensee of a long-term care home shall ensure that, unless otherwise directed by the Minister, at least once in every year a survey is taken of the

residents, their families and caregivers to measure their experience with the home and the care, services, programs and goods provided at the home.

The licensee failed to ensure that the Resident and Family/Caregiver Experience survey was taken of the residents' families and caregivers to measure their experience with the home and the care, services, programs and goods provided at the home.

Rationale and Summary:

A review of the home's 2024 Resident and Family/Caregiver Experience Survey indicated that it did not include residents' families and caregivers as survey participants.

Staff members acknowledged that the survey did not include the residents' families and substitute decision-makers.

Failure to include the residents' families and caregivers in the Resident and Family/Caregiver Experience Survey may result in them missing an opportunity to participate in the home's continuous quality improvement program.

Sources: Resident Satisfaction Survey 2024, interviews with staff members.

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WRITTEN NOTIFICATION: FAMILY COUNCIL

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 65 (7) (b)
Family Council
s. 65 (7) If there is no Family Council, the licensee shall,
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council.

The licensee failed to convene semi-annual meetings of residents' families and persons of importance to residents to advise the right to establish a Family Council.

Rationale and Summary:

A family council was not established in the home.

The Administrator acknowledged that no semi-annual meetings were convened with residents' families and persons of importance to residents to advise them on their right to establish a Family Council in the home, as required.

Failure to convene the meetings may result in the non-establishment of a family council in the home.

Sources: The family newsletters and interview with the Administrator.

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WRITTEN NOTIFICATION: Exceptions, portable or window air conditioning

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 23.2 (4) (a)
Uninstalling portable or window air conditioning
s. 23.2 (4) A licensee who uninstalls or does not install a portable air conditioning unit or a window air conditioning unit in accordance with a resident's request shall promptly include in the plan of care for each resident in the room,
(a) any specific risk factors that may lead to heat related illness as a result of the lack of an air conditioning unit.

The licensee failed to ensure that any specific risk factors were included in a resident's plan of care that may lead to heat related illness as a result of the uninstallation of the air-conditioning unit.

Rationale and Summary:

The home did not install a window air-conditioning unit in the resident's room as requested by the resident. A review of resident's health records indicated that no risk factors were identified and included in the resident's plan of care that may lead to heat-related illness as a result of the non-installation of the air-conditioning unit.

Staff members acknowledged that no specific risk factors were identified, and interventions were developed before the non-installation of the air-conditioning unit in the resident's room.

Failure to identify the specific risk factors that may lead to heat-related illness due to the lack of air conditioning increased the residents' risk of developing heat-related illness.

Sources: Review of resident's clinical records, interviews with staff members.

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WRITTEN NOTIFICATION: Cooling requirements

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 23 (2) (c)
Cooling requirements
s. 23 (2) The heat related illness prevention and management plan must, at a minimum,
(c) identify specific interventions and strategies that staff are to implement to prevent or mitigate the identified risk factors that may lead to heat related illness and to prevent or mitigate the identified symptoms of such an illness in residents;

The licensee failed to ensure that specific interventions and strategies were developed for a resident to prevent or mitigate the identified risk factors that may

lead to heat related illness and to prevent or mitigate the identified symptoms of such an illness.

Rationale and Summary:

The home's heat-related illness prevention and management plan required staff to identify residents who are at high risk of heat-related illness and develop heat-related interdisciplinary resident care plans.

According to the heat risk assessment, the resident was identified as at high risk. The resident's plan of care did not include specific interventions and strategies to prevent or mitigate the risk factors that may lead to heat-related illness.

Director of Care (DOC) stated that the resident's plan of care should have included specific interventions and strategies to prevent or mitigate the risk factors that may lead to heat-related illness.

Failure to develop specific interventions and strategies increased resident's risk of developing heat-related illnesses.

Sources: The home's "Heat Related Illness Prevention and Management Plan" Procedures, resident's clinical records and interview with the DOC.

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WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (b)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive

hypoglycemia involving a resident is,
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider. O. Reg. 66/23, s. 30.

The licensee failed to ensure that a medication incident involved with a resident was reported to the substitute decision maker (SDM).

Rationale and Summary:

The resident had a medication incident and it was not reported to the resident's SDM.

Staff members acknowledged that the medication incident involving the resident was not reported to the SDM as required.

Failure to report the medication incident to the SDM hindered the SDM's ability to participate in the resident's care.

Sources: Home's Quarterly review of medication incidents, interviews with staff members.

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