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

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Original Public Report

Report Issue Date: November 26, 2024

Inspection Number: 2024-1027-0003

Inspection Type:
Complaint
Critical Incident

Licensee: Gem Health Care Group Limited

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 10 - 12, 2024 and October 8 - 10, 11, 15 - 18, 22 and 23, 2024.

The following Complaint intakes were inspected:

•Intake: #00119396 was related to improper care
•Intake: #00119975 was related to housekeeping
•Intakes: #00121199 and #00119760 were related multiple care related concerns
•Intake: #00121867 was related to admissions to home

The Following Critical Incident System (CIS) intakes were inspected:

•Intake: #00126229, CIS #1041-000011-24 was related to a disease outbreak
•Intake: #00128371, CIS #1041-000012-24 was related to unexpected death of a resident.

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: AUTHORIZATION FOR ADMISSION TO A HOME

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (7) (b)
Authorization for admission to a home
s. 51 (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 50 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements.

The licensee has failed to demonstrate withholding approval for an applicant's admission to the Long-Term Care Home (LTCH) was based on a lack of nursing expertise to meet the applicant's care requirements.

Rationale and Summary:

The Director received a complaint related to an applicant being denied admission to the LTCH.

The applicant required a daily administration of a drug to treat a health condition. The application documents noted the applicant was stable but also exhibited responsive behaviours.

Director of Care (DOC) and Administrator indicated the LTCH had a narcotics and Behavioural Support Ontario (BSO) programs in place, but that nursing staff required additional training specific to the administration of the drug. The Administrator indicated that if the applicant was accepted into the LTCH, they would be waitlisted. The Administrator acknowledged that in that time period, the LTCH would be able to have required processes and procedures, training and equipment in place.

Failing to ensure the LTCH denied admission to the applicant based on a lack of nursing expertise to meet the applicant's care requirements prevented the applicant's transition into the LTCH.

Sources: The applicant's application documents, refusal letter, Interviews with DOC and Administrator.

WRITTEN NOTIFICATION: AUTHORIZATION FOR ADMISSION TO A HOME

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (9) (d)
Authorization for admission to a home
s. 51 (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(d) contact information for the Director.

The licensee has failed to ensure a written notice withholding approval for admission to the LTCH included contact information for the Director.

Rationale and Summary:

The LTCH wrote a letter withholding admission that was signed by the Administrator.

The Administrator acknowledged the letter did not include contact information for the Director.

In failing to include contact information for the Director, the applicant may not have been made aware of how to lodge a complaint with the Ministry of Long-Term Care (MLTC).

Sources: The refusal letter and Interview with Administrator.

WRITTEN NOTIFICATION: AUTHORIZATION FOR ADMISSION TO A HOME

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (10) 1.
Authorization for admission to a home
s. 51 (10) The persons referred to in subsection (9) are the following:
1. The applicant.

The licensee has failed to ensure a written notice withholding approval for admission to the LTCH was given to an applicant

Rationale and Summary:

The LTCH wrote a letter withholding admission that was signed by the Administrator.

The Administrator acknowledged the refusal letter was not sent directly to the applicant and only to the placement co-ordinator.

In failing to directly notify the applicant, the LTCH did not provide proper notice.

Sources: Refusal letter and interview with Administrator.

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 19.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks.

The licensee failed to ensure that a resident's plan of care included interventions for safely performing an Activities of Daily Living (ADL) task with respect to an identified risk.

Rationale and Summary:

The resident had a history of difficulty with certain aspect of an ADL task, and exhibited specific behaviours. On a particular date, the resident experienced an incident during the ADL task that required interventions. However, the resident's

plan of care lacked specific interventions to assist and supervise the resident during this task and to manage their behaviours despite the identified risk.

On a certain date while performing this task, the resident had an adverse reaction. A PSW acknowledged that the resident was not supervised during the task.

Both DOC and Clinical Nurse Manager acknowledged that resident's plan of care should have included specific interventions to mitigate the risks associated with their behaviours during the ADL task.

Failure to develop and implement specific plan of care interventions for assisting and supervising the resident during the ADL task, based on their risk factors, increased their risk.

Sources: Resident's health records, interviews with staff members.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 11.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
11. Ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care. O. Reg. 246/22, s. 102 (7).

The licensee has failed to ensure that the infection prevention and control lead

(IPAC lead) carried out their responsibilities related to the hand hygiene program.

Specifically, IPAC Standard for Long-Term Care Homes, s. 9.1 (b) states that the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include: Hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

Rationale and Summary:

A PSW was observed assisting a resident with ADL task without performing hand hygiene beforehand. The PSW confirmed that they did not perform hand hygiene prior to assisting the resident and acknowledged that they should have.

IPAC Lead stated that staff were required to perform hand hygiene before and after contact with the resident.

Failure to follow proper hand hygiene practices poses an increased risk of exposure to infection transmission.

Sources: Inspector's observations, interviews with staff members, and IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023).

WRITTEN NOTIFICATION: Emergency plans

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (4) 1. vi.
Emergency plans
s. 268 (4) The licensee shall ensure that the emergency plans provide for the

following:
1. Dealing with emergencies, including, without being limited to,
vi. medical emergencies,

The licensee failed to ensure that a Registered Practical Nurse (RPN) attended to a resident immediately when they identified that the resident was having a medical emergency.

Rationale and Summary:

In accordance with O. Reg. 246/22, s. 11(1) (b), the licensee is required to ensure that there are policies developed for managing medical emergencies. The home's policy required that upon recognizing the specific adverse health event, registered staff members should immediately attend to the resident, assess the situation, and initiate appropriate interventions.

On a certain date, the resident experienced an adverse health event. The RPN recognized the incident but did not immediately attend to the resident; instead, they went to seek the assistance from the Registered Nurse (RN).

The RPN acknowledged that they did not follow the policy by failing to immediately attend to the resident. The Director of Care (DOC) confirmed that registered staff members are required to provide immediate attention to residents in the event of a medical emergency.

Failure of the registered staff to attend to the resident immediately upon recognizing the medical emergency increased the risk of delayed and potentially inadequate intervention.

Sources: The CIS, the home's policy, interviews with staff members.