Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 7, 2016	2016_251512_0002	T-2792-15	Critical Incident System

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Fountain View Care Community
1800 O'Connor Drive East York ON M4A 1W7

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

TILDA HUI (512)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 25, 26, 27, 28 & 29, 2016.

This critical incident inspection is related to a critical incident in the home reported to the Director on June 24, 2015. Intake associated with this inspection: T-2792-15.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of care (DOC), Registered Practical Nurse (RPN), Personal Support Workers (PSWs).

During the course of the inspection, the inspector conducted observations in home and resident area, observations of care delivery processes, review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that if the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, different approaches have been considered in the revision of the plan of care.

Record review of an identified critical incident (CI) report, revealed an altercation occurred between residents #001 and #002 on an identified date. The incident occurred in the hallway of an identified unit of the home and was witnessed by an identified staff. Assessments for both residents were conducted and there was no injury noted. A CI report was submitted to the Ministry of Health & Long Term Care (MOHLTC) on the same day. On the Analysis and Follow-up section of the CI report, it was stated that an identified community resource agency will see the resident on next visit next week.

Review of resident #001's current written plan of care indicated that interventions have been developed to address the responsive behaviors of the resident.

Record review revealed resident #001 was referred to two identified community resource agencies on an identified date three months before the critical incident date, as the resident was exhibiting increased responsive behavior. The resident was followed-up by both agencies and was discharged by the first identified agency on an identified date as his/her responsive behavior was observed to have decreased. The resident was put on an identified medication adjusted by the physician on the second community resource team. However, review of the progress notes on Point-Click-Care (PCC) revealed and interview of RPN #001 confirmed that resident #001 had four episodes of responsive behaviors following the discharge by the identified community resource agency and before the critical incident on the identified date.

Further review of the resident’s progress notes indicated during the six months after the resident was discharged by the first identified community resource agency, the resident was documented to have multiple episodes of responsive behaviors, ranging from one to six episodes per month.

Record review indicated no evidence that the first identified community resource agency was consulted to address the continuous responsive behaviors of the resident. Interviews with RPN #001 and the DOC confirmed that the identified community resource agency was not consulted following the CI on the identified date, to recommend new interventions when the exiting interventions were not effective in reducing the resident's responsive behaviors. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that if the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, different approaches have been considered in the revision of the plan of care, to be implemented voluntarily.

Issued on this 8th day of March, 2016

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.