

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

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

**Long-Term Care Homes Division
Long-Term Care Inspections Branch**

**Division des foyers de soins de
longue durée
Inspection de soins de longue durée**

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de
Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 30, 2019	2019_644507_0024	011361-18	Complaint

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM 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

STELLA NG (507)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 24, 25, 26 and 29 (off-site interview), 2019.

**The following intake was inspected:
Log #011361-18 related to plan of care.**

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Nurse Practitioner (NP), Registered Nurse (RN), Personal Support Workers (PSW) and Substitute Decision-Maker (SDM).

During the course of the inspection, the inspector conducted observations of staff to resident interactions, care provisions, record reviewed health records and relevant policies and procedures.

**The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Personal Support Services**

During the course of this inspection, Non-Compliances were issued.

1 WN(s)

0 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**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. (9) The licensee shall ensure that the following are documented:

- 1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
- 2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
- 3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).**

Findings/Faits saillants :

The licensee has failed to ensure that effectiveness of the plan of care was documented for resident #001.

A complaint was received by the Director regarding the care resident #001 received. During a conversation with the complainant, resident #001's substitute decision-maker (SDM) voiced concerns that the resident sustained an injury with no known cause in an identified month.

A review of resident #001's progress notes indicated the following documentation:

- On an identified date (day one), specified conditions were observed on the resident.
- On the next day, resident was assessed by the Nurse Practitioner (NP) and physiotherapist (PT) due to the specific conditions. Investigation and intervention were ordered.
- On the seventh day, received investigation report which indicated an injury.

Further review of resident #001's progress notes indicated there was no documentation between day three and day six, in regards to the status of the specific conditions or the effectiveness of the intervention.

In an interview, staff #106 acknowledged there was a gap in documentation related to the status of resident #001's specific conditions on the days followed the discovery of the conditions. [s. 6. (9) 3.]

Issued on this 30th day of July, 2019

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

Original report signed by the inspector.