Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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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
Nov 30, 2021	2021_769646_0018	005073-21, 016451-21, 016537-21	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 Toronto ON M4A 1W7

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

IVY LAM (646), APRIL CHAN (704759)

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): October 13, 14, 15, 18, 19, 20, 21, 22, and 25; and November 23, 24, and 25, 2021.

The following complaint intake was completed in this inspection:
Log #005073-21 regarding allegations of abuse and neglect.

The following Critical Incident System (CIS) intakes were completed in this inspection:
Log #016451-21 (CIS # 2836-000023-21) related to allegations of abuse and neglect, and falls; and
Log #016537-21 (CIS # 2836-000024-21) related to fracture of unknown cause.

NOTE: The following findings identified in this report were issued in concurrent inspection report #2021_769646_0020:
- A Written Notification and Voluntary Plan of Correction related to LTCHA, s. 6. (4) was identified for a resident.
- A Written Notification and Voluntary Plan of Correction related to LTCHA, s. 6. (7) for a resident.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Assistant Directors of Care (ADOCs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Assessment Instrument (RAI) Coordinator, Skin and Wound Champion, Falls Lead, Physiotherapist (PT), Complainant, and Residents.

During the course of the inspection, the inspectors conducted a tour of the home, made observations related to the home's care processes; staff to resident, and resident to resident interactions; conducted reviews of residents' record reviews, and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who exhibited altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

The resident was found with altered skin integrity and was assessed by a Registered Practical Nurse (RPN). The subsequent skin assessment was completed five days after the expected weekly assessment date.

The RPN indicated they did not get to completing the resident on the seventh day, and completed five days after the expected date. They further indicated any registered staff could complete the follow up on a weekly skin assessment.

Another RPN indicated no order alerts came up to reassess the resident, as there was no treatment ordered for the skin alteration. The RPN further indicated it was not their practice to check the User-Defined Assessments (UDA), but they would now check the UDA to determine which residents require weekly skin assessments.

The skin and wound champion and the Director of Care (DOC) indicated a skin and wound evaluation was to be completed weekly when a resident was identified with altered skin integrity, and staff were to check UDA to know when to complete residents' weekly skin assessment. This was not done for the resident, and their weekly skin assessment was delayed for five days.

There was a risk that the resident would not receive timely skin assessments and further action or treatment when the staff did not complete their weekly skin assessment as required.

[Sources: Critical Incident System (CIS) Report; Resident's progress notes; x-ray result; Digital Prescriber's order; Skin and Wound Evaluations; Interviews with Personal Support Worker (PSW); Registered Practical Nurses (RPNs), Skin and Wound champion; Physiotherapist (PT); Director of Care (DOC), and other staff.] [s. 50. (2) (b) (iv)]

Issued on this 1st day of December, 2021

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

Original report signed by the inspector.