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
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
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Original Public Report

Report Issue Date: November 1, 2023	
Inspection Number: 2023-1321-0005	
Inspection Type: Complaint	
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	
Long Term Care Home and City: Fountain View Community, Toronto	
Lead Inspector Chinonye Nwankpa (000715)	**Inspector Digital Signature** Chinonye Nwankpa Digitally signed by Chinonye Nwankpa Date: 2023.11.07 09:23:46 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 19-20, 23-24, 2023

The following intake was completed during this complaint inspection:

- Intake #00097990 related to neglect, skin and wound care, continence care, menu planning, and bathing.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control

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)

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in their plan.

Rationale and Summary
A resident complained to the Home that staff had not been applying a specific medical device they needed for several months. The care plan noted the resident required this device daily.

The records reviewed did not include any information on the device being applied.

The Personal Support Worker (PSW), Registered Practical Nurse (RPN) and Associate Director of Care (ADOC) acknowledged the device had not been applied on the resident as indicated in their care plan.

Failing to apply the device impacted the resident's wellbeing, and increased their risk for negative health outcomes.

Sources: Resident's clinical records; interviews with resident, PSW, RPN, and ADOC. [000715]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of care was documented, specifically the daily application of a device as set out in the plan of care.

Rationale and Summary
A resident's care plan noted they required a specific medical device applied daily, and for the parts of the device to be changed on a specified schedule.

The resident’s clinical records revealed there was no documentation of the application of the device.

During an interview, a RPN shared that they applied the device on the resident on an identified date and changed the device parts as scheduled, however they did not document the application. The RPN and ADOC confirmed there was no documentation of the application of the device. Furthermore, the RPN acknowledged there were days when the device was not applied, but there was no documentation of these instances.

There was risk indicated when the device application was not documented as directed in the plan of care.

Sources: Resident’s clinical records; interviews with RPNs and ADOC. [000715]