Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: February 20, 2024

Inspection Number: 2023-1321-0006

Inspection Type:
Complaint
Critical Incident

Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP

Long Term Care Home and City: Fountain View Community, Toronto

Lead Inspector	**Inspector Digital Signature**
Chinonye Nwankpa (000715)	

Additional Inspector(s)
Ryan Randhawa (741073)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 18- 22, 27- 28, 2023 and January 2- 5, 8-11, 12, 2024.

The inspection occurred offsite on the following date(s): January 16, 2024.

The following intake(s) were inspected in this Critical Incident (CI) Inspection:

- Intake: #00104556 – CI #2836-000030-23, Intake: #00099733 – CI #2836-000021-23, Intake: #00100547 – CI #2836-000022-23, Intake: #00100726 – CI #2836-000023-23- related to outbreaks
- Intake: #00101383 – CI #2836-000024-23 - Improper care
- Intake: #00103390 – CI #2836-000027-23 - Staff to resident physical abuse

- Intake: #00103494 – CI #2836-000028-23 - Fall prevention and management
- Intake: #00098995 – CI #2836-000020-23- Resident to resident physical abuse.

The following intake(s) were inspected in this complaint inspection:

- Intake: #00103407 - Related to fall incident resulting in injuries following elopement, as well as previous elopements
- Intake: #00102388 - Related to plan of care, fall prevention, improper footcare and nail care, and administration of drugs.
- Intake: #00103307 - Related to potential physical abuse or improper care, injury of unknown cause, pain assessments, and communication and response system

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

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 (1) (a)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that there was a written plan of care for a resident that set out the planned care for the resident, specifically regarding nail and foot care.

Rationale and Summary
The home's policy stated that foot care was to be provided on residents bath days and documented. The policy further noted that residents on a specific medication should not receive foot care from Personal Support Workers (PSWs), rather nurses were responsible for provision of this care because of potential risks.

The clinical records of a resident showed there were receiving the specific medication. There was no documentation of nail and foot care performed by staff.

A PSW and Registered Nurse (RN) both reported that PSWs were responsible for providing nail and foot care to the resident on their bath days, and that the care had not been documented. The Director of Care (DOC) verified that the registered nursing staff were responsible for the resident's foot care because they were receiving a medication specified in their policy.

When there was no planned nail care and foot care for the resident, it increased the risk of inconsistent and improper care.

Sources: Resident’s clinical records, the home’s policies; interviews with the PSW, RN, DOC, and others. [000715]

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5700 Yonge Street, 5th Floor
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Telephone: (866) 311-8002

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
Involvement of resident, etc.
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure a resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of their plan of care.

Rationale and Summary
A resident experienced episodes of an illness on two consecutive dates. The home's investigation records showed that PSWs who found the resident immediately reported the illness to the charge nurse, however the substitute decision-maker was not informed.

The resident's clinical records showed they had further episodes of the specific illness for which they were sent to the hospital.

An Associate Director of Care (ADOC) acknowledged the RN failed to inform the substitute decision-maker about the change in the resident's condition.

Failing to inform the substitute decision-maker when the resident's health condition changed impacted their ability to fully participate in the plan of care.
Sources: Resident's clinical records, the home's investigation notes; interview with the ADOC. [000715]

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

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

Rationale and Summary
1) A resident was at risk of falls and staff were to encourage the resident to apply a specific device as a fall and injury prevention strategy. On a specific date, the resident was observed without the device.

A PSW verified that they failed to encourage the resident to use the device. A RN confirmed that the resident required staff to encourage them to apply the device.

The resident was at increased risk of injuries related to a fall when staff failed to encourage them to wear the device as specified in their plan of care.

Sources: Observations; resident's clinical records; interviews with the PSW, RN, and others. [741073]

2) A resident sustained an unwitnessed fall resulting in an injury when they fell outside the home.

The resident's care plan indicated that they were at risk for falling and exhibiting specific responsive behaviours, and that they required reminders to use a specific

aide. The home's policy stated that PSWs were to monitor and supervise residents exhibiting the above responsive behaviours when they were off the unit.

A receptionist and PSW both indicated that staff were not supervising the resident when they fell. A Registered Practical Nurse (RPN) explained that the resident was at risk for falls and needed reminders when they failed to use their specific aide. The PSW and RPN both acknowledged that staff should have supervised the resident when they left the unit and reminded them to use their specific aide.

When staff did not supervise the resident off the unit, it increased their risk for falling and sustaining an injury.

Sources: Resident's clinical records, the home's policy; interviews with the PSW, Receptionist, RPN, and others. [741073]

3) A resident was missing from a secured unit. The staff later found the resident in another area of the home with no injuries.

The resident's care plan included a specific behaviour strategy for their safety.

The specific responsive behaviour intervention was not implemented when an RPN discovered the resident was missing. A charge nurse indicated that the resident's responsive behaviour intervention should have been in place.

There was an increased risk of responsive behaviours when the specific interventions were not provided, as per the resident's care plan.

Sources: Resident's clinical records; interviews with the PSWs, RPN, RN, and others. [741073]

WRITTEN NOTIFICATION: Documentation

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
Documentation
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.

The licensee has failed to ensure that the provision of the care set out in the plan of care for a resident was documented.

Rationale and Summary
A resident sustained a fall outside of the home. As a result, staff were to document provision of an intervention at specified intervals. Upon review of the resident's records, a PSW did not document the provision of this intervention at specific times during their shift.

A PSW and an ADOC both acknowledged that the provision of care was not documented by the PSW.

There was increased risk to the resident when staff failed to document the provision of the care.

Sources: Resident's clinical records; interviews with the PSW and ADOC. [741073]

WRITTEN NOTIFICATION: Complaints Procedure- Licensee

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives

concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to immediately forward to the Director any written complaint received concerning the care of a resident.

Rationale and Summary
Written complaints were sent to the home through electronic mail (email), however they were not forwarded to the Director.

The emailed complaints were sent on eleven occasions.

The DOC acknowledged that these emails were received by the home and acted on, however they failed to forward them to the Director.

Failing to report written complaints to the Director increased the risk of delayed follow up actions.

Sources: Email correspondence; interview with the DOC. [000715]

WRITTEN NOTIFICATION: Binding on Licensees

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
Binding on licensees
s. 184 (3) Every licensee of a long-term care home shall carry out every operational

or policy directive that applies to the long-term care home.

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every Minister's Directive that applied to the long-term care home, the Minister's Directive was complied with.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, the licensee was required to ensure that the masking requirements set out in the COVID-19 guidance document for long-term care homes in Ontario, effective November 7, 2023, were complied with.

Rationale and Summary
The COVID-19 guidance document for long-term care homes in Ontario, effective November 7, 2023, directed the homes that masks were required to be worn indoors in all resident areas by all staff, students, volunteers, and support workers.

An observation revealed a RPN was not wearing a mask when administering a treatment to a resident. The RPN acknowledged they should have been wearing a mask.

Failure of the staff to wear a mask as required by the COVID-19 guidance document, could increase the risk for transmission of communicable disease to others.

Sources: Observations; Minister's Directives: COVID-19 response measures for long-term care homes (August 30, 2022); COVID-19 guidance document for long-term care homes in Ontario (November 07, 2023); interviews with RPN, and others. [741073]

WRITTEN NOTIFICATION: Doors in a Home

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to the areas by residents, and the doors were kept locked when they were not being supervised by staff.

Rationale and Summary
The door to the clean utility room was noted to be unlocked without staff supervising the door. The clean utility room contained various items including personal hygiene products and hazardous materials.

A RPN and the DOC both indicated that the clean utility room was a non-residential area and should have been locked to restrict access to residents. The RPN acknowledged that the locks on this door should have been in use and in working order.

Failure to ensure that the door leading to a non-residential area was kept locked when it was not being supervised by staff put the residents at risk of exposure to hazardous materials in the room and increased the potential for injury.

Sources: Observations; interviews with the RPN and DOC. [741073]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Rationale and Summary
A resident experienced an episode of an illness, on two consecutive dates. The home's investigation records showed PSWs who discovered the resident when they experienced the illness immediately reported it to the charge nurse.

The oncoming nursing staff and physicians were not informed of the change in resident's condition. The resident's clinical records revealed there was no subsequent documentation of an assessment, interventions, or the resident's responses to interventions.

PSWs verified that the resident experienced episodes of an illness during their shift which they reported to an RN. An ADOC acknowledged the RN failed to document about resident's condition or their actions and the resident's response to interventions. Hence, the oncoming shift were unaware of the change in the resident's condition.

When staff failed to document about the resident's condition and subsequent interventions, it increased the risk of poor monitoring and delayed treatment of their illness.

Sources: Resident's clinical records, the home's investigation notes; interviews with the PSWs and ADOC. [000715]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible

The licensee has failed to ensure that when a resident who demonstrated responsive behaviours, strategies were implemented to respond to these behaviours.

Summary and Rationale
A resident exhibited responsive behaviours while they exited the home. A Receptionist, Activity Aide (AA), and RN attempted without success to redirect the resident back to the home. The resident sustained a fall with injury outside of the home and was transferred to the hospital.

The resident had a history of responsive behaviours, and their care plan specified interventions to manage the behaviours. The Receptionist, AA, and RN indicated that they did not implement the specific responsive behaviour strategies.

The home's policy required PSWs to supervise residents who exhibited specific responsive behaviours especially when they exited the unit. The Receptionist and AA both indicated that the resident was not supervised when they exited the unit. A PSW acknowledged that they should have supervised the resident off the unit and implemented the specific responsive behaviour management strategies in their care plan.

There was risk of harm when the resident's responsive behaviour interventions were not implemented by staff.

Sources: Resident's clinical records, the home's policy; interviews with the PSW, Receptionist, RPN, RN, and others. [741073]

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (2)
Reports re critical incidents
s. 115 (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 246/22, s. 115 (2).

The licensee has failed to report a critical incident after normal business hours using the Ministry's method for after hours emergency contact.

Rationale and Summary
Outbreak critical incident reports were submitted by the home after normal business hours. The home did not use the Ministry's method for after hours emergency contact.

The Ministry of Long-Term Care (MLTC) Reporting Requirements - reference sheet sent out on August 18, 2023, indicated that for critical incidents report immediately outside of business hours, to call the Service Ontario After Hours Line.

The IPAC lead confirmed that the home submitted a critical incident report but did not call the Service Ontario After-Hours Line.

Failing to report the outbreak critical incidents after normal business hours using the Ministry's method for after hours emergency contact increased the risk of delayed actions by the Director.

Sources: Critical Incident Reports, MLTC Reporting Requirements - reference sheet; interview with the IPAC Lead. [741073]

COMPLIANCE ORDER CO #001 Plan of Care

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
Integration of assessments, care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1) Conduct an audit to ensure that shift to shift collaboration occurs, at minimum on three units per week on all shifts (day, evening, and night) on each unit, for

a period of two weeks following service of this order. Ensure that each unit is audited at least once during this period. The shift-to-shift collaboration should include resident incidents and residents who have had a change in condition, the interventions being endorsed to the upcoming shift, documentation of the incident or change in condition, and the subsequent updates to their care plans where applicable.

2) Maintain a record of the audits completed, including but not limited to, date of audit, person completing the audit, unit audited, staff and resident audited, outcome and actions taken as a result of any deficiencies identified.

3) Retrain and educate all registered staff (RPNs and RNs) on:
   - The home's shift to shift exchange protocols and expectations,
   - The home's nursing staff documentation policy and expectations, specifically to cover documentation of resident incidents and change in condition.

4) Maintain a record of the education, including the content, date, signatures of staff members who attended and the staff member who provided the education.

Grounds
The licensee has failed to ensure that the staff involved in the different aspects of care of residents collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and consistent with and complemented each other.

Rationale and Summary
1) A resident was discovered with a change in skin condition. The home's investigation records showed that the resident reported pain and exhibited responsive behaviours during the shift before the skin condition was found. Upon

review of the nursing progress notes, there was no documentation found on the reported pain and the responsive behaviour incident.

PSWs confirmed that the resident exhibited responsive behaviours during their shift. A RPN expressed that the resident reported pain on a specific body area. The RPN stated they provided pain intervention, however it was not effective. A RN who worked the next shift when the skin condition was discovered knew nothing about the unresolved pain and the responsive behaviour incident from the previous shift as nothing had been communicated to them.

Failing to collaborate with other staff regarding the resident's pain and responsive behaviour increased the risk of delayed follow up.

Sources: Resident's clinical records, the home's investigation notes; interviews with the PSWs, RPN, and RN, [000715]

2) A resident sustained a fall which resulted in an injury. The post-fall assessment identified the resident needed proper footwear, however there was no change made to the resident's care plan. The resident was observed wearing unsafe footwear.

A RN verified that when the resident fell, their footwear came off. This footwear was described as unsafe. The RN identified this risk factor but failed to inform the Substitute Decision Maker (SDM) or collaborate with other relevant staff. As a result, the RN acknowledged the resident continued to wear the unsafe footwear and have subsequent falls.

Failing to collaborate with other staff regarding the resident's fall prevention interventions increased their risk of further falls and injury.

Sources: Observations; resident's clinical records; interviews with the RN. [000715]

3) A resident experienced episodes of an illness. The home's investigation records showed PSWs who found the resident when they experienced these episodes reported it to the charge nurse immediately. However, the oncoming nursing staff and physicians were not informed of these episodes.

PSWs verified that the resident experienced this illness during their shift, but other than reporting to the charge nurse, there was no further endorsement to the oncoming shift. A RPN and RN both confirmed that they did not receive any information pertaining to the change in condition of the resident that occurred the previous shift.

An ADOC acknowledged that the RN failed to inform the oncoming shift and the physicians about the resident's condition.

Failing to collaborate with the oncoming shift and medical staff when the resident's health condition changed increased the risk of delayed treatment and interventions.

Sources: Resident's clinical records, the home's investigation notes; interviews with the PSWs, RPN, RNs, and ADOC. [000715]

This order must be complied with by April 20, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.