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_0001	T-2262-15	Complaint

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 Complaint inspection.

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

This complaint inspection is initiated as result of a complaint reported to the Ministry of Health and Long Term Care's centralized intake on March 31, 2015. Intake associated with this inspection: T-2262-15.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of care (DOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSWs), Pharmacist, Physiotherapist (PT), Physiotherapist Assistant (PTA), and Activation Assistant.

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:
Continence Care and Bowel Management
Medication
Personal Support Services
Reporting and Complaints

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

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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. (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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Review of resident #001's current written care plan indicated that the resident was assessed by physiotherapy as having identified physical conditions requiring physiotherapy interventions. Physiotherapy staff developed strategies to improve the resident's physical status three times per week.

Interviews with physiotherapy staff #001 and #002 revealed the resident was receiving physiotherapy exercises twice weekly instead of three times per week as stated in the current written care plan. Physiotherapy staff #002 confirmed the written care plan should have been revised to state physiotherapy session frequency of twice weekly which was provided to the resident currently.

Interview with the DOC confirmed that the written care plan should have been revised to reflect the current treatment for the resident and set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at any other time when the resident's care needs change.

Review of resident #001's bladder and bowel continence assessment conducted on an identified date indicated the resident was incontinent of bladder and bowel functions. Review of the resident's current written care plan revealed interventions were developed to address the resident's bladder incontinence. The resident required toileting during the day and evening, and wears incontinent briefs to be changed at night.

Interviews with an identified family member of the resident who visited daily for a period of time, indicated that the resident was put into bed at an identified time in the afternoon as requested by the family member. The family member stated the reason being the resident was not eating well at dinner time, so the family member would feed the resident food brought from home before he/she left in the afternoon, and the resident would stay in bed for the rest of the evening.

Interviews with PSW #007 & RN #006 revealed staff were putting resident in bed by the identified time in the afternoon as requested by the family member. The resident would not be toileted as stated in the current care plan, but his/her incontinent briefs would be changed twice in the evening at specified times. RN #006 confirmed that the new routine had been going on for the last four weeks.

Review of the current written plan of care did not reveal any indication of the above mentioned arrangement being documented. Interviews with RN #006 and the DOC confirmed that the resident was not reassessed and the plan of care was not revised when the resident's care needs changed. [s. 6. (10) (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 the plan of care set out clear directions to staff and others who provide direct care to the resident, and the resident is reassessed and the plan of care reviewed and revised at any other time when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent have an individualized plan of care to promote and manage bowel continence based on the assessment.

Review of resident #001's bladder and bowel continence assessment conducted on an identified date indicated the resident was incontinent of bladder and bowel functions. Review of the resident's current written plan of care revealed interventions were developed to address the resident's bladder incontinence. The resident required toileting during the day and evening, and wears incontinent briefs to be changed at night. However, there was no interventions set up to address the resident's issue of bowel incontinence.

Interviews with PSW #007 indicated the resident was incontinent of bowel functions. Interviews with RPN #004 and the DOC confirmed that there were no interventions set up in the current written care plan to address the resident's bowel incontinence. The DOC stated that the home has a bowel protocol which was expected to be included in the written care plan to meet the resident's bowel incontinence care needs. [s. 51. (2) (b)]

2. The licensee has failed to ensure that the resident who is unable to toilet independently some or all of the time receive assistance from staff to manage and maintain continence.

Review of resident #001's current written care plan indicated the resident was incontinent of bladder functions and required toileting regularly to maintain continence. The resident

was to be toileted by two staff with the aid of transferring equipment during the day shift at three time intervals: in the morning, mid-day and early afternoon.

Interview with an identified family member of the resident who visited daily for a period of time indicated the resident was only toileted at mid-day daily and not at other time intervals.

Observations made on two identified dates and times during the inspection period did not reveal any toileting for the resident being performed by the staff.

Interviews with RPN #004 and PSW #005 revealed the resident was toileted at mid-day once during the day shift. PSW #005 stated the resident would be toileted at early afternoon for approximately 50 per cent of the time. Toileting at other times would not be performed especially when the unit was short staffed.

Interview with the DOC confirmed that the resident should have received assistance from staff to be toileted to maintain continence. [s. 51. (2) (c)]

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 the resident who is incontinent have an individualized plan of care to promote and manage bowel continence based on the assessment, and the resident who is unable to toilet independently some or all of the time receive assistance from staff to manage and maintain continence, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

Observations conducted on an identified unit of the home on two identified dates and times during the inspection period, noted one nail clipper kept in a drawer in the nail clipper cabinet in the clean utility room. Nail debris was noted inside where the nail clipper was kept. Smaller drawers were observed in the cabinet labeled with individual room numbers. No other nail clippers were observed inside the approximately 30 small drawers.

Interviews with RPN #004 and PSW #005 indicated residents were supposed to have their individual nail clippers for staff to perform nail care. PSW #005 stated that he/she had informed the charge nurse before to order new nail clippers for individual residents, however has not received them. Charge nurse of the unit, RPN #004, was not aware that residents did not have their individual nail clippers.

Interview with the DOC confirmed that residents were expected to have their own individual nail clippers for use and will look into ordering new ones for the residents. [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any written complaints that have been received concerning the care of a resident or the operation of the home is immediately forwarded to the Director.

Interview with an identified family member of resident #001 revealed the family had submitted a written complaint letter via email to the home on an identified date, regarding care provided to the resident in the home. The concerns raised were discussed previously during a multidisciplinary care conference held one month ago. As this family member did not speak English, a second family member from another city called in to translate during the care conference. The DOC requested that the issues be captured in a written letter for ease of following up. As the submitted letter was written in a language other than English, the DOC requested that the letter be translated into English. A letter in English with the concerns was emailed to the DOC two weeks after the first letter. Record review did not reveal evidence of the concern letter being forwarded to the Director on or after the date the letter was received by the home.

Interview with the DOC confirmed that the written complaint letter was not forwarded to the Director as required by legislation. [s. 22. (1)]

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.