Ontario

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 13, 2016	2016_398605_0021	031911-16	Critical Incident System

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

SARAH KENNEDY (605)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 7 & 8, 2016.

The following critical incident (CI) inspection was conducted: 031911-16 (related to abuse and neglect).

During the course of the inspection, the inspector(s) spoke with the executive director (ED), director of care (DOC), a registered nurse (RN), a registered practical nurse (RPN), personal support workers (PSWs), residents and substitute decision makers.

During the course of the inspection, the inspector(s): observed resident to resident interactions and reviewed resident health care records, relevant policies and procedures, training documents and the videotaped surveillance for the date and time of the incident.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 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	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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee has failed to ensure resident #002 was protected from abuse by anyone and free from neglect by staff.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means the use of physical force by a resident that causes physical injury to another resident.

For the purposes of the definition of “neglect” in section 5 of the Regulations, “neglect” means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A review of a critical incident report (CIR) revealed on an identified date and time, staff discovered resident #001 in resident #002’s bedroom. Resident #002 stated resident #001 hit him/her with an identified object. Resident #002 was sent to hospital for assessment of injuries. Police were contacted and substitute decision makers were notified. One to one monitoring for resident #001 was initiated. At the time of the incident, PSW #101, PSW #102 and RPN #103 were working on the unit.

Both resident rooms are on the same side of the hallway on an identified unit (there is one resident room between the identified resident rooms).

An interview with resident #001 revealed he/she did not recall the incident and he/she was not able to carry on a conversation with inspector #605. An interview with resident #002 revealed he/she witnessed resident #001 enter his/her room during the night and resident #001 proceeded to hit him/her with the identified object. Resident #002 stated he/she did not call for help and forgot to use the call bell. Resident #002 stated he/she was in pain and scared at the time of the incident. A skin assessment from after the incident revealed resident #002 sustained injuries.

An interview with PSW #101 revealed she was the float PSW on the unit during the night when the identified incident occurred. PSW #101 stated she left the unit (at an unidentified time, sometime after 2340h) after she was finished helping PSW #102 with resident care and she went to another unit to assist staff. PSW #102 continued to provide one person care to residents. PSW #101, PSW #102 and RPN #103 all stated they did not witness resident #001 leave his/her room and enter resident #002's room. Furthermore, they all stated they did not hear any unusual noises during this time.

PSW #101 and PSW #102 both stated they did rounds together to check on residents residing on the unit. Both PSW #101 and PSW #102 confirmed when they discovered

resident #001 in resident #002's room, at approximately 0200h, resident #001 was observed sitting in the chair beside resident #002's bed. Both PSWs revealed resident #002 stated resident #001 hit him/her multiple times with the identified object.

A review of the home's video surveillance from the date of the incident, revealed two staff members exited resident #002's room at approximately 2340h on the date of the incident and proceeded down the hallway, going in and out of resident rooms providing care. At 0012h, resident #001 was observed walking down the hall, and entering resident #002's room. At this time no staff were observed in the hallway. Further review of the video revealed no staff member looked into or entered resident #002's room until 0159h. The review of the video surveillance confirmed resident #002 was not checked on for two hours and 19 minutes and resident #001 was in resident #002's room for one hour and 47 minutes. Both PSW #101 and #102 stated staff should check on residents every hour.

An interview with the DOC confirmed resident #002 was not protected from physical abusive by resident #001. The DOC stated she expects staff to check on residents at least every hour. Resident #002 was neglected by staff as staff did not check on resident #002 at least every hour as per the home's practice.

The scope of this non-compliance is isolated as it relates to one resident. The severity is actual harm/risk. The home's compliance history report reveals a history of non-compliance in unrelated areas. As a result of the scope, severity and the licensees previous compliance history, a compliance order is warranted.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 22nd day of December, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SARAH KENNEDY (605)
Inspection No. / No de l'inspection :	2016_398605_0021
Log No. / Registre no:	031911-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 13, 2016
Licensee / Titulaire de permis :	2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP 302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8
LTC Home / Foyer de SLD :	Fountain View Care Community 1800 O'Connor Drive, East York, ON, M4A-1W7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gary Butt

To 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that residents are protected from abuse and neglect by anyone. The plan shall include the development and implementation of a system of ongoing monitoring to:

1) ensure that the behavioural triggers for residents with responsive behaviours are identified, and applicable strategies and interventions are developed and implemented in the written care plan in order to prevent resident to resident abuse, and staff to resident neglect, and
2) ensure staff are complying with the homes policy and procedures related to zero tolerance of abuse and neglect in order to protect residents from being abused by other residents in the home, and to prevent residents from being neglected by staff, and
3) ensure staff are monitoring residents as per the homes expectation of at least hourly and more frequently as determined by assessment.

This plan is to be submitted via email to inspector sarah.kennedy@ontario.ca by December 23, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure resident #002 was protected from abuse by anyone and free from neglect by staff.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means the use of physical force by a resident that causes physical injury to another resident.

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The scope of this non-compliance is isolated as it relates to one resident. The severity is actual harm/risk. The home's compliance history report reveals a history of non-compliance in unrelated areas. As a result of the scope, severity and the licensees previous compliance history, a compliance order is warranted. (605)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 30, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 13th day of December, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sarah Kennedy

Service Area Office /
Bureau régional de services : Toronto Service Area Office