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

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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
Jan 30, 2017	2017_491647_0001	035257-16	Resident Quality Inspection

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

JENNIFER BROWN (647), VALERIE PIMENTEL (557)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 4, 5, 6, 9, 10, 2017

The following critical incident was inspected concurrently with this inspection: 000035-17 related to an unexpected death.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), and Personal Support Workers (PSW), Residents, Family Members, and Substitute Decision Makers.

During the course of the inspection, the inspectors conducted observation in home and residents' areas, observation of care delivery processes including medication passes and meal delivery services, and 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
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Skin and Wound Care

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_398605_0021	647

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. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the PASD described in subsection (1) that is used to assist a resident with a routine activity of living is included in the residents' plan of care.

During stage 1 of the homes' RQI it had been observed that an identified resident had been in bed with two half side rails raised. It had been observed at this time that resident had been able to turn over in bed and hold himself/herself on his/her side to allow direct care staff to provide care.

An interview with a PSW indicated that resident uses two side rails while in bed to assist him/her in an activity of daily living. The PSW further indicated that the resident is able to roll himself/herself over in bed and sit up in bed using these side rails.

A clinical chart review revealed that the use of two bedrails used as a PASD had not been included in the residents' plan of care. A further review of the clinical chart which had included the plan of care revealed that there had not been any documentation relating to the use of a PASD in the progress notes, assessments or in the Minimum Data Set assessment (MDS).

An interview with an RN indicated that residents who require a PASD are required to have it included in the residents' plan of care. The RN further indicated that there had not been any documentation in the plan of care for the identified resident relating to the use of a PASD.

An interview with the Director of Care further confirmed that any resident that requires the use of a PASD for a routine activity of daily living is required to be included in the residents' plan of care. [s. 33. (3)]

2. The licensee has failed to ensure the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living included in a resident's plan of care only if the use of the PASD has been approved by
i. a physician
ii. a registered nurse
iii. a registered practical nurse
iv. a member of the College of Occupational Therapists of Ontario
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations.

During stage 1 of the homes' RQI it had been observed that an identified resident had been in bed with two half side rails raised. It had been observed at this time that resident had been able to turn over in bed and hold himself/herself on his/her side to allow direct

care staff to provide care.

An interview with a PSW indicated that resident uses two side rails while in bed to assist him/her in an activity of daily living. The PSW further indicated that the resident is able to roll himself/herself over in bed and sit up in bed using these side rails.

A clinical chart review revealed that the use of two bedrails used as a PASD had not been approved by a physician, registered nurse, registered practical nurse, a member of the College of Occupation Therapists of Ontario, a member of the College of Physiotherapists of Ontario or any other person provided for in the regulations. A further review of the clinical chart which had included the plan of care revealed that there had not been any documentation relating to the use of a PASD in the progress notes, assessments, or in the Minimum Data Set assessment (MDS). The consent for the use of a PASD had been found in the identified residents' chart however had been blank at time of chart review. The home subsequently completed the consent form and received approval by the physician for the use of the PASD after the inspector observed it to be blank.

An interview with an RN indicated that residents who require a PASD are required to have it approved by the above mentioned regulated parties. The RN further indicated that there had not been any approval for the use of the two bedrails to be used as a PASD for the identified resident.

An interview with the Director of Care confirmed that any resident that requires the use of a PASD for a routine activity of daily living is required to have approval from the above mentioned parties prior to implementation. The DOC further confirmed that there had not been approval prior to using the bedrails as a PASD for the identified resident. [s. 33. (4) 3.]

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 PASD described in subsection (1) that is used to assist a resident with a routine activity of living is included in the residents' plan of care and to ensure the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living included in a resident's plan of care only if the use of the PASD has been approved by
i. a physician
ii. a registered nurse
iii. a registered practical nurse
iv. a member of the College of Occupational Therapists of Ontario
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan, policy, protocol, procedure, strategy or system is complied with.

The MediSystem Pharmacy policy, Subject: "Medication Pass - MAR/TAR sheets", Index Number: "04-02-10", review date of June 23, 2014, identified that when a medication is administered, the nurse must initial at time of administration. Secondly, MediSystem Phamacy orientation package for medication administration identified the registered staff during the time of administration must document on Narcotic and Controlled Drug Administration Record (NaCDAR), the nurse is to document the administration of the medication at the time the drug is removed.

Record review of the NaCDAR revealed for nine identified residents, the count on this record and the quantity of medication that remained on the blister pack did not match.

An interview with an identified RPN confirmed that he/she did not document on the NaCDAR at the time of administering the above mentioned medications to the identified resident's.

An interview with the DOC confirmed that the identified RPN did not follow the homes policies for medication administration and it is an expectation that the registered staff sign the NaCDAR at the time of the administration of the medication. [s. 8. (1) (b)]

Issued on this 1st day of February, 2017

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

Original report signed by the inspector.