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 # / No de registre	Type of Inspection / Genre d'inspection
Jan 9, 2018	2017_642606_0021	028344-17	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd. Suite 300 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

JANET GROUX (606), SARAH KENNEDY (605)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 12, 13, 14, 15, 19, 20, 21, and 22, 2017.

The following intakes were inspected concurrently with the RQI:
A Critical Incident (CI) regarding transfer to the hospital due to an injury.
A Complaint (CO) regarding care issues.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), the Director of Environmental Services, Infection Control (IC) Lead, Social Worker (SW). Physiotherapist (PT), Recreation Assistant (RA), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), housekeeping, private duty caregiver (PDC), president of the Residents' Council, Substitute Decision Makers (SDM), and Residents.

During the course of this inspection, the inspectors toured the home, observed resident care, observed staff and resident interactions, observed a resident medication administration, observed infection control staff practices, interviewed the Residents' Council (RC) president, reviewed resident health records, meeting minutes, schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **3 VPC(s)**
- **0 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents were fully respected and promoted: 11. Every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

The inspector observed the following:
-On an identified date, time and home unit the inspector observed a number of different point of care (POC) monitor screens left open and unattended. Two of the POC screens exposed personal health information for residents' #004, and #013 which was visible to others nearby.
-On an identified date and time on an identified unit, the inspector observed a POC screen located near an identified resident room left unattended with resident #014's personal health information visible to anyone nearby.

Interview with PSW #127 indicated he/she was aware that the home's practice was prior to walking away from the POC, he/she must sign and log off and indicated he/she had forgotten to log off from the POC.

Interviews with the Director of Environmental Services (DES) and the Director of Care (DOC) indicated that staff must ensure to protect residents' health information and must log off from the POC prior to leaving the area.

The licensee failed to ensure that the following rights of residents were fully respected and promoted: 11. Every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act. [s. 3. (1) 11. iv.]

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 following rights of residents are fully respected and promoted: 11. Every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, to be implemented voluntarily.

WN #2: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(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. 2007, c. 8, s. 6 (4).

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

Review of a Critical Incident Report (CI) indicated resident #011 was found by PSW #109 on the floor in his/her room in an identified position. The resident was assessed by RPN #111 and noted no injuries or discomfort. On an identified date, it was noted that resident #011 verbalized pain when an identified part of his/her body was moved by staff.

Resident #011 was reassessed by RPN #111 and was transferred to the hospital and returned to the home on an identified date with an identified medical diagnosis.

Review of resident #011's progress notes on an identified date indicated the resident was found in an identified position by the bedside in his/her room. Resident #011 was assessed by RPN #111, however resident #011 had refused the RPN to perform an identified assessment to an identified area of the resident's body. The progress notes indicated that the resident did not show any signs of distress and there were no identified signs or symptoms to an identified area of his/her body was noted. Further review indicated that resident #011 was assessed by the Physiotherapist (PT) after the fall with no noted injuries. The resident was placed on head injury monitoring for the rest of the evening and night shift with no indication of any injuries and discomfort.
On an identified date, RPN #111 assessed resident #011 at an identified time, and indicated that when the resident was touched and re-positioned in his/her chair, staff had observed resident #011 to be observed with pain and indicated the resident verbalized that he/she had pain. The progress notes indicated the resident had a history of an identified medical condition prior to being admitted to the home. Resident #011 was then transferred to the hospital for an identified medical procedure to an identified area of his/her body.

Review of resident #011's progress notes on an identified date indicated resident was admitted to the home with several identified medical diagnoses. The progress notes indicated that the resident had a history of an identified responsive behaviour. Further review of the progress notes indicated a physiotherapy assessment was completed during the resident's admission with the goals to reduce the risk of future falls and injury with several identified falls prevention strategies.

Review of resident #011's written care plan indicated the resident was high risk for falls related to an identified medical diagnosis, medication regime, and responsive behaviours and indicated identified fall prevention strategies however, the care plan did not include the identified PT's falls prevention strategies recommendations.

Interview with the PT indicated that resident #011 was admitted to the home with an identified medical condition sustained during a fall in the hospital prior to being admitted to the home and indicated that resident #011 was high risk for falls and recommended for the resident to have the identified recommended falls prevention strategies to be in place.

Interview with PSW #109 indicated he/she did not witness resident #011's fall and was unaware as to whether the resident had climbed out of bed or not. The PSW indicated that the resident was high risk for falls and indicated that residents who are high risk for falls like resident #011, staff should be keeping the resident close to them during care for closer monitoring. PSW #109 indicated he/she does not know why resident #011 was in his room at the time he/she fell as the resident usually does not go to sleep until much later in the evening.

Interview with RN #112 indicated that once the PT has completed his/her assessment, the nursing staff reviews the PT's recommendations and updates the care plan to include the recommended interventions. The RN indicated that the recommendation for the resident to have an identified fall prevention strategy to reduce further falls injury was not in place until after resident fell on an identified date.

Interview with the Assistant Director of Care (ADOC) indicated that after the PT has completed his/her assessment of the resident's risk for falls, the registered staff will review the assessment and recommendations and initiate a care plan and does not know the reason as to why the staff did not initiate the recommendations for resident #011 to have the PT's recommended falls prevention strategies in place.

The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other. [s. 6. (4) (a)]

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

During the Resident Quality Inspection (RQI), staff interview resident #004 triggered for falls and that the resident had a fall in the last 30 days.

Review of resident #004's progress notes dated on an identified date, indicated that a staff member witnessed the resident fall on an identified part of his/her body when the resident lost his/her balance while walking in the hallway. The progress notes stated that the resident #004 was assessed with no injuries.

Review of resident #004's written care plan indicated the resident was at high risk for falls related to identified responsive behaviours, medical regime and indicated staff to ensure

resident was provided identified falls prevention strategies to be in place.

Interview with resident #004's Private Duty Caregiver (PDC) indicated that resident #004 was high risk for falls. The PDC indicated to manage resident #004's risk of injuries from falling, resident wears an identified falls prevention devices. The PDC indicated that resident #004 can be resistive to care and will at times refuse to wear the identified fall prevention devices and required staff to re approach him/her to ensure the identified falls prevention devices were on.

The inspector observed on an identified date and time during the RQI, resident #004 was walking in the hallway with his/her PDC and was not wearing an identified falls prevention device. Interview with the PDC indicated that he/she was not aware that the staff had not applied the identified falls prevention device that morning. The PDC indicated that had he/she known the resident was not wearing the identified falls prevention device, he/she would have applied the identified falls prevention device on the resident.

Interview with PSW #130 indicated that resident #004 should have had the identified falls prevention device on and was unaware he/she did not have it on. PSW #130 indicated that resident #004 was dressed in the early morning by the night staff and can sometimes be resistive to putting on the identified falls prevention device but it would have been communicated to the day staff during report. The PSW indicated that he/she did not hear a report that resident #004 did not have the identified falls prevention device on. The PSW indicated he/she did not check to see if the resident had on the identified falls prevention device and should have.

Interview with RPN #131 indicated resident #004 was not aware that resident #004 was not wearing the identified falls prevention device and indicated that the reason may be because the identified falls prevention device may be in the laundry or still in his/her room. The RPN indicated he/she will follow up with PSW #130.

Interview with the ADOC indicated that staff are responsible to ensure that the interventions in the plan of care are followed and indicated that residents who require an identified falls prevention device as a falls prevention intervention were provided at least an identified number of the identified falls prevention device by the home to ensure that staff have an identified falls prevention device available to apply on the resident when the other was not available.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #004 as specified in the plan. [s. 6. (7)]

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 staff and others involved in the different aspects of care of the resident collaborate with each other, (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other;
-to ensure that the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) receives a skin

assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, and (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

During the RQI, stage one of abaqis, resident #002 triggered for dignity lacking and abuse during a resident interview.
Resident #002 stated during the interview that some staff did not treat him/her with dignity and respect during care. The resident indicated he/she was not aware that he/she had sustained any injuries from the identified treatment of staff during care.

Review of resident #002's progress notes between an identified time period, indicated documentation of an identified responsive behaviour toward staff during care. The progress notes indicated resident has generalized pain and experienced most of the pain to an identified areas of his/her body and indicated the resident has a history of a number of identified medical conditions that contributed to his/her pain. Further review of the progress notes indicated documentation of resident #002 displaying an identified responsive behaviour towards a staff member and had described the reason why he/she displayed the identified responsive behaviour toward the staff member. The progress notes indicated that on an identified date, resident #002 was noted with an identified skin integrity impairment to an identified area of his/her body reported by staff with an unknown cause. On an identified date, documentation indicated resident #002's Substitute Decision Maker (SDM) reported to RPN #118 that he/she was concerned and verbalized staff to be gentle with resident #002 during care. Further documentation on an identified date, resident #002 was noted with an identified skin integrity impairment on an identified area of his/her body during evening care with an unknown cause. On an identified date, the progress notes indicated resident #002 was noted with an identified skin integrity impairment to an identified area of his/her body during evening care and did not indicate the cause of the skin integrity impairment.

Review of resident #002's written plan of care did not indicate any interventions to manage and prevent resident's skin integrity impairment as noted above.

Review of resident #002 Point Click Care (PCC) assessments did not indicate that an assessment was completed for the skin integrity impairment noted on the three identified dates.

Interview with RPN #118 indicated that staff reported to him/her of the skin integrity

impairment noted on resident #002 as noted above and indicated the causes of the skin integrity impairment were unknown and indicated he/she documented the skin integrity impairment in the progress notes but did not complete a skin assessment in the PCC. The RPN indicated resident #002 skin is very fragile skin and can be resistive to care but was unable to indicate a reason as to how the resident sustained the identified skin integrity impairment.

Interview with the ADOC indicated that a resident who has been identified with a skin integrity impairment including bruises will have an initial skin assessment completed in the PCC and reassessed weekly until resolved.

The home failed to ensure that resident #002 received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, and reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. [s. 50. (2) (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 (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, and (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

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Rapport d’inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 23rd day of January, 2018

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

Original report signed by the inspector.