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
Jul 13, 2018	2018_630589_0005	009595-18	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM 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

JOANNE ZAHUR (589), BABITHA SHANMUGANANDAPALA (673), JOY IERACI (665), VERON ASH (535)

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): May 16, 17, 18, 22, 23, 24, 25, June 4, 5, 6, 7, 8, 12, 13, 14, 15, 28, 29, and 31, 2018.

The following critical incident system reports (CIS) were inspected concurrently with this resident quality inspection (RQI):
-Logs #017752-17/CIS #2836-000016-17, #027210-17/CIS #2836-000032-17, #027208-17/CIS #2836-000033-17 related to Abuse, #000444-18 related to Responsive Behaviours and Prevention of Abuse, #011272-17/CIS #2836-000012-17 and #028197-16/CIS #2836-000033-06 related to Plan of Care, #027449-17/CIS #2836-000034-17 related to Falls Prevention, and #007166-17/CIS #2836-000008-17 related to Administration of Drugs.

The following complaints were inspected concurrently with the RQI:
-logs #003334-18 was inspected concurrently with the RQI related to Responsive Behaviours and Prevention of Abuse and Neglect, and #030836-16 related to Housekeeping, Administration of Drugs, Communication and Response System, Dealing with Complaints, Residents' Bill of Rights, Reporting Certain Matters to the Director, Food Production, Non-allowable Resident Charges, Continence Care and Bowel Management and Duty to Protect.

Please note inspector Rebecca Leung #726 was also present during this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Directors of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Nurse Practitioner (NP), Physiotherapist (PT), Dietary Aide (DA), Family Council chair, Residents' Council chair and Substitute Decision-Maker (SDM).

During the course of the inspection, the inspector(s) observed meal services, staff to resident interactions, resident to resident interactions, and the provision of care, reviewed health records, staff training records, and any relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **7 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 :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and not neglected by the licensee or staff in the home.

A Critical Incident Report (CIR) was submitted to the Ministry of Health and Long Term Care (MOHLTC) related to staff to resident abuse.

A review of the CIR indicated resident #037, had reported to staff #147 that staff #150 had entered their room at an identified time and struck them.

A review of the home's investigation notes included a note from staff #147 indicating resident #037 had continued to state that an identified staff member had come into their room and struck them. A review of an assessment completed for resident #037 indicated their memory recall included the ability to recall staff names/ faces. In separate interviews, staff #148 and staff #114 described staff #150's skin tone as described by resident #037.

A review of the schedule/roster for the night shift on an identified date indicated staff #150 had been working on resident #037's resident home area (RHA).

In interviews, staff #147 and staff #129 stated resident #037 was cognitive and lucid when they had reported the incident of alleged abuse. Staff #147 further stated resident #037 was also able to recall the incident to them again the next day. A review of the home's investigation notes also contained a note with a statement by staff #149 that resident #037 was cognitively well.

In an interview, staff #114 stated resident #037 had reported to them they had discomfort in an identified body area as a result of someone on an identified shift striking them.

Further review of the home's investigation notes contained a letter addressed to staff #150 that stated the home had completed an investigation as a result of an allegation of abuse reported by a resident against staff #150. The letter further indicated that the actions had been substantiated and staff #150 had been disciplined.

In interviews, staff #148 and staff #149 acknowledged striking a resident is considered physical abuse.

In an interview, staff #129 defined physical abuse as any action causing harm to a resident, and stated staff #150 had been disciplined as there were concerns they had provided improper care. [s. 19. (1)]

2. The MOHLTC received a CIR related to staff to resident abuse involving resident #054. The CIR report indicated that someone had come into resident #054's room and struck identified body areas when care was being provided. The CIR further indicated no injuries were noted but resident #054 had experienced harm. The home conducted an investigation and as a result the staff involved had been disciplined for resident abuse.

In an interview, resident #054 was unable to answer questions regarding the incident.

A review of an assessment completed indicated resident #054's long and short term memory was okay and the resident was able to recall staff names/faces.

In an interview, staff #114 indicated they were told by resident #054 that a staff member had caused them harm.

A review of the home's investigation notes indicated staff #153 stated that staff #150 would speak inappropriately towards resident #054. Another identified PSW indicated to the home that they could hear from the hallway when staff #150 spoke inappropriately in residents' rooms.

In an interview, staff #150 indicated they had provided care to resident #054 however, denied the allegation of physical abuse towards resident #054, even though they had received a discipline as a result of the home's internal investigation.

In an interview, staff #129 indicated after the home had conducted an investigation, and that staff #150 had been disciplined as a result of physical abuse towards resident #054. [s. 19. (1)]

3. The MOHLTC received a complaint from resident #004's family member. The complainant indicated the resident had not been provided hygiene care for an identified period of time.

A review of the home's complaints binder indicated the incident occurred on an identified date in June 2016, on an identified shift. The home had conducted an investigation which indicated resident #004 had requested personal care at an identified time of the day. The investigation notes further indicated resident #004 had informed staff #151, who communicated resident #004's request to their assigned staff #152. The home's investigation also indicated staff #152 had been made aware of resident #004's need for personal care, but the resident waited for staff #152 to check on them and then was

provided personal care an identified time later.

In interviews, staff #124 and staff #122 indicated when a resident has requested personal care to be provided, it is expected that staff provide care as soon as they are able. Staff #124 and staff #122 indicated it would be neglect if a staff had been aware that a resident required personal care and had been made to wait for a long time.

In an interview, staff #151 indicated they had informed the assigned PSW to resident #004 that they required personal care. Staff #151 could not recall the name of that PSW at the time of this interview.

Resident #004 was interviewed but was unable to recall the incident.

Further review of the investigation notes indicated that resident #004 exhibited responsive behaviours as a result of not receiving personal care in a timely manner.

In an interview, staff #152 indicated they had been made aware that resident #004 had required personal care by staff #151. When asked why resident #004 waited an identified amount of time for personal care to be provided, staff #152 indicated they thought the resident had just been soiled.

In an interview, staff #129 stated staff #152 had been disciplined as a result of not providing personal care to resident #004 in a timely manner.

The home failed to ensure that resident #004 was free from neglect by staff #152. [s. 19. (1)]

Additional Required Actions:

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

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 staff collaborated with each other in the implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The Nutrition and Hydration Inspection Protocol (IP) triggered for resident #014 from stage one of the RQI.

A review of the current written plan of care for resident #014 under the activities of daily living (ADL) self-care performance focus, directed staff to serve meals in a specified manner.

Observations conducted by the Inspector indicated resident #014 had not been served their meal in the specified manner.

A review of the diet list located in the servery had not indicated the specified manner in which to serve resident #014.

In an interview, staff #100 indicated they had not served resident #014 in the specified manner at meal service.

In an interview, staff #101 indicated they followed the diet list located in the servery during meal service to know the diet of residents and specified manner in which to serve them. DA #101 indicated they had not served the resident in the specified manner as the

diet list had not included the use of this specific intervention.

In an interview, staff #132 reviewed the written plan of care and the diet list for resident #014, and indicated staff #101 would not have known about the use of an intervention as it had not been on the diet list. Staff #132 indicated staff #100 had to communicate to the DA regarding the need for the intervention for the resident. Staff #132 agreed the nursing and dietary departments had not collaborated with each other in the implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complement each other. [s. 6. (4) (b)]

2. The licensee has failed to ensure the care set out in the plan of care had been provided to resident #007 as specified in the plan.

The Falls Prevention IP triggered for resident #007 in stage one of the RQI.

A review of resident #007's health record indicated they had been admitted to the home with underlying health conditions. A review of an assessment completed for resident #007 indicated moderate cognitive impairment. A review of the home's electronic documentation system indicated a history of incidents with a risk score that indicated resident #007 was at high risk for falls.

A review of resident #007's current written plan of care indicated that identified interventions were in place.

In an interview, staff #104 stated they have one safety device for resident #007 that was used for both their mobility aid and bed. Staff #104 further stated they move resident #007's safety device between their bed and mobility aid as needed.

Observations by the Inspector indicated resident #007 was in bed sleeping with the mobility aid positioned near the bed. Further observations indicated the safety device placed on the left upper corner of the mattress, not turned on and the connecting safety sensor device draped over the mobility aid and not placed underneath the resident.

In an interview, staff #110 acknowledged the safety device had not been placed onto the bed when resident #007 had been transferred to bed.

In an interview, staff #118 acknowledged that care had not been provided to resident #007 as specified in the plan. [s. 6. (7)]

3. The Nutrition and Hydration IP triggered for resident #014 from stage one of the RQI.

A review of the current plan of care for resident #014 under the nutrition focus indicated resident was to be provided with specific dietary needs.

Observations conducted by the Inspector indicated resident #014 had not been provided their specific dietary needs at a meal service.

In an interview, staff #100 verified they had not served resident #014 their specific dietary needs. Staff #100 said the plan of care had not been followed as specified in the plan of care.

In an interview, staff #132 stated staff #100 had not followed the plan of care for resident #014 as specified in the plan. [s. 6. (7)]

4. The MOHLTC received a CIS report related to staff to resident abuse.

A review of the current written plan of care for resident #054, directed staff to provide specific care needs.

Observations conducted by the Inspector indicated resident #054 was observed sitting and attached to a mechanical transfer aid, alone. PSW staff were not observed to be in the resident's room. At an identified time, resident #054 had called for assistance.

In an interview, staff #105 stated they had left resident #054 alone as their colleague required assistance with another resident. Staff #105 further stated that resident #054 required two person assistance for their care needs. When asked if resident #054 was to have been left alone staff #105 indicated they should have not left resident #054 alone as resident had been exhibiting responsive behaviours and, was at risk of injury.

In an interview, staff #119 stated it is the home's process for staff to remain in the room when residents are being provided personal care. Staff #119 further stated resident #054 required two people for all aspects of care. Staff #119 also stated that resident #054 exhibits responsive behaviours and staff are required to be in the room when the resident is being provided personal care. When asked what the risk was for resident #054 being left alone the RN indicated the resident had been at risk for incidents and getting injured. Staff #119 agreed that the care set out in the plan of care had not been provided to

resident #054 as specified in the plan.

In an interview, staff #118 stated resident #054's written plan of care indicated two person for all aspects of care. Staff #118 agreed that resident #054's plan of care was not provided 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 they collaborate with each other in the implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, and to ensure the care set out in the plan of care had been provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse or neglect of a resident by anyone that resulted in harm or a risk of harm to the resident had occurred or may occur shall immediately report the suspicion and the information upon which is was based to the Director.

The MOHLTC received a CIS report related to staff to resident abuse involving resident #054. The CIS report indicated resident #054's family member had informed the unit staff resident #054 had an injury, and the resident had indicated staff had touched them inappropriately on an identified shift.

A review of the progress notes for resident #054 indicated on two identified dates in July 2017, resident #054's family member had informed an identified RPN and staff #102 working in the resident home area (RHA) that resident #054 had an injury. The RPN asked resident #054 how they had gotten the injury and the resident indicated that somebody had touched them inappropriately.

During the inspection, attempts to contact the identified RPN noted above were unsuccessful.

In an interview, staff #102 indicated the information received from resident #054's family member was considered to be an allegation of abuse. The RN indicated that it is the home's process for any suspicion or witnessed abuse to be reported to the in-charge nurse, who will then inform management. The RN further stated that any allegation of abuse and neglect had to be reported to the MOHLTC. When asked if the allegation had been reported to the in-charge nurse, the RN indicated they had not informed the in-charge nurse at the time, but had written a letter addressed to staff #118 and #132 about the allegation.

In an interview, staff #118 stated an investigation had been initiated and that it is the home's abuse and neglect policy for any suspected or witnessed abuse to be reported to the MOHLTC immediately. When an allegation or suspected abuse had occurred on weekends, staff #118 stated the MOHLTC after-hours phone number is to be called to report the allegation or suspicion of abuse. The staff stated they were aware of the letter that staff #102 wrote regarding the allegation of abuse. Staff #118 indicated the above mentioned incident had been considered to be suspected abuse and should have been reported immediately to the MOHLTC on the identified date in July 2017, instead of four days later. [s. 24. (1)]

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 a person who had reasonable grounds to suspect that abuse of a resident by anyone by the licensee or staff that resulted in harm or a risk of harm to the resident had occurred or may occur shall immediately report the suspicion and the information upon which is was based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #015 had fallen, the resident had been assessed that a post-fall assessment had been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The Fall Prevention IP triggered for resident #015 in stage one of the RQI.

A review of resident #015's progress note documentation identified they had experienced an incident. The progress note further revealed resident #015 had fallen out of bed and that a post fall assessment had not been completed. A review of a quarterly risk assessment completed indicated resident #015 was at high risk for falls.

In an interview staff #119 stated they had been informed by staff that resident #015 had experienced an incident. Staff #119 further stated they had initiated a post falls assessment however, had not completed it as resident #015's incident had not occurred on their shift and they were not aware of all the assessment details.

In an interview staff #131 stated resident #015's incident had occurred on an identified shift and that they had not worked that shift. Staff #132 further stated when they came to work on their scheduled shift, the outgoing staff member had endorsed that the home's electronic documentation system had not been functioning on the previous shift and staff had documented in resident #015 chart's paper documentation notes.

A review of resident #015's health record indicated that a paper version of the identified post assessment had not been completed.

In an interview, staff #118 provided multidisciplinary notes from resident #015's chart documenting the incident. Staff #118 acknowledged the multidisciplinary notes would not be considered a post assessment and that staff should have completed a post assessment once the electronic documentation issue had been resolved.

In an interview, staff #131 verified that a post assessment had not been completed for resident #015's incident. [s. 49. (2)]

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 when a resident falls, they are assessed, that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The MOHLTC received CIS report related to improper/incompetent treatment of a resident that resulted in harm or risk to resident #049. The CIS report indicated RPN #142 had administered an identified medication for resident #049's medication at an alternate time instead of the prescribed time on two specific dates in April 2017.

A review of resident #049's physician's orders and electronic medication administration record indicated the resident had been ordered an identified medication to be given at a prescribed time since an identified date in October 2014.

A review of the home's investigation notes indicated staff #142 had administered resident #049 an identified medication at an alternate time than was prescribed.

In an interview, staff #142 indicated they had not administered resident #049's identified medication in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least quarterly, there was a documented reassessment of each resident's drug regime.

In preparation for the mandatory medication observation, a review of resident #055's clinical paper chart indicated they did not have a current quarterly reassessment of the resident's drug regime. The resident's chart had a quarterly drug regime reassessment for an identified period between March to May 2018. The sample was expanded and a review of resident #004's clinical paper chart also indicated they did not have a current quarterly reassessment of the resident's drug regime. Resident #004's chart indicated a quarterly drug regime reassessment for an identified period between March 2018 to May 2018.

A review of two resident home area's quarterly medication review binders, indicated a quarterly drug regime reassessment for resident #055 and #004 for an identified period between June 2018 to August 2018, which had not been signed by the registered staff and the physician.

In interviews, staff #119 and #120 stated the quarterly medication reviews are sent by the pharmacy one to two weeks prior to the next review. The RNs indicated the quarterly medication reviews are processed when the registered staff and physician signs off on the review. Staff #119 reviewed resident #055's clinical record and staff #120 reviewed resident #004's clinical record and both residents did not have a current quarterly reassessment of their drug regimes completed.

In an interview, staff #132 indicated that quarterly medication reviews are processed when it is reviewed and signed by two registered staff and the physician. Staff #132 stated residents' #055 and #004 had not had a quarterly reassessment of their drug regime completed for the current quarter [s. 134. (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 at least quarterly, there is a documented reassessment of each resident's drug regime, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

The home's medication incidents were reviewed for the mandatory medication IP during the RQI.

A review of a medication incident report for resident #056 indicated an identified medication had not been administered at the prescribed time. Resident #056 had been assessed and did not have pain as a result of the medication incident.

A review of the medication incident report and progress notes indicated that the family had not been notified of the medication incident.

In an interview, staff #132 reviewed resident #056's medication incident report and progress notes and verified that the family had not been notified of the medication incident. [s. 135. (1)]

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 every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #8: 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 staff participate in the implementation of the infection prevention and control program.

During the initial tour of the home, the Inspector observed the following personal items unlabelled in the third floor shower room:

-inside the shower area on two separate shelves there were one used hair brush; and two bars of soap, and
-within the same shower room, and inside the toilet area there were unlabeled personal items including one tube of tooth paste, one used blue wash basin, and two used pink wash basins sitting on the counter of the sink.

In an interview, staff #119 confirmed that all personal items should be labelled and returned to the resident's room after the shower has been completed. Staff #119 removed and discarded unlabeled personal items as appropriate from the shower and toilet areas; and removed the wash basins to the soiled equipment storage area.

In an interview, staff #132 verified that PSWs should have labelled residents' personal items; and ensure they were returned to the resident's room after the shower. Therefore, the licensee failed to ensure staff participated in the home's IPAC program. [s. 229. (4)]

2. 1) Observations conducted by the Inspector at a meal service indicated staff #113 had removed used soup bowls from residents' place settings and then served main entrees to residents #011, #050, #051, #052 and #053 without performing hand hygiene.

In an interview, staff #113 stated they should have performed hand hygiene after handling used soup bowls and prior to serving main entrees to the residents noted above to prevent infection.

2) Observations conducted by the Inspector in the shared washroom of room 349, indicated toothpaste was observed on the washroom counter without a cap.

In an interview, staff #122 indicated the toothpaste should have been stored with a cap to prevent infection.

3) Observations conducted by the Inspector revealed the following:
-shared washroom in an identified room had a wash basin upside down on the toilet,
-shared washroom in an identified room had a toothbrush without a protective cover lying on the left side of the counter, and
-shared washroom in an identified room had a wash basin upside down on the toilet.

In an interview, staff #135, stated they had left the wash basin in room 349 to dry on the toilet. Staff #135 stated wash basins should have been stored on the wire shelf located in resident washrooms. Staff #135 stated it was not appropriate for them to leave the wash basin to dry over the toilet for infection control.

In an interview, staff #125, stated toothbrushes should be stored in a kidney basin or on the washroom counter if the toothbrush had a protective cover for infection control.

In an interview, staff #132 agreed that staff had not participated in the implementation of the home's infection prevention and control program. [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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure there was a monitoring system in place to record each resident's height on admission and annually thereafter.

On completion of census record reviews in stage one of the RQI for residents' #040, #041, and #042, they indicated that annual heights had not been measured and documented annually.

Resident #040, #041 and #042's heights had last been measured in December 2016.

In an interview, staff #134 confirmed the dates each resident's heights had been last documented, and stated that residents' heights should have been measured and documented annually. In an interview, staff #131 verified that all residents' heights should have been measured and documented annually. [s. 68. (2) (e) (ii)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared.

In an interview, staff #129 stated the annual evaluation of their policy to promote zero tolerance of abuse and neglect had been conducted for 2017. However, at the time of the inspection, the home had been unable to provide documentation that the 2017 evaluation had been conducted. [s. 99. (e)]

Issued on this 3rd day of August, 2018

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) :	JOANNE ZAHUR (589), BABITHA SHANMUGANANDAPALA (673), JOY IERACI (665), VERON ASH (535)
Inspection No. / No de l'inspection :	2018_630589_0005
Log No. / No de registre :	009595-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 13, 2018
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, 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) (a)

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 must be compliant with s.19 (1) of the Act.

Specifically, the licensee must ensure that residents #054 and #037 are protected from abuse by staff and resident #004 is protected from neglect by staff. The licensee must have all direct care staff educated on the home's policy on Abuse Prevention and Neglect to ensure all residents are protected from abuse and neglect. The licensee must also keep a record of the date the education was provided, signatures of all direct care staff who attended and who provided the education.

Grounds / Motifs :

1. The MOHLTC received a complaint from resident #004's family member. The complainant indicated the resident had not been provided personal care for an identified period of time.

A review of the home's complaints binder indicated the incident occurred on an identified date in June 2016, on an identified shift. The home had conducted an investigation which indicated resident #004 had requested personal care at an identified time of the day. The investigation notes further indicated resident #004 had informed staff #151, who communicated resident #004's request to their assigned staff #152. The home's investigation also indicated staff #152 had been made aware of resident #004's need for personal care, but the resident waited for staff #152 to check on them and then was provided personal care an identified time later.

In interviews, staff #124 and staff #122 indicated when a resident has requested personal care to be provided, it is expected that staff provide care as soon as

they are able. Staff #124 and staff #122 indicated it would be neglect if a staff had been aware that a resident required personal care and had been made to wait for a long time.

In an interview, staff #151 indicated they had informed the assigned PSW to resident #004 that they required personal care. Staff #151 could not recall the name of that PSW at the time of this interview.

Resident #004 was interviewed but was unable to recall the incident.

Further review of the investigation notes indicated that resident #004 exhibited responsive behaviours as a result of not receiving personal care in a timely manner.

In an interview, staff #152 indicated they had been made aware that resident #004 had required personal care by staff #151. When asked why resident #004 waited an identified amount of time for personal care to be provided, staff #152 indicated they thought the resident had just been soiled.

In an interview, staff #129 stated staff #152 had been disciplined as a result of not providing personal care to resident #004 in a timely manner.

The home failed to ensure that resident #004 was free from neglect by staff #152. [s. 19. (1)] (665)

2. The MOHLTC received a CIR related to staff to resident abuse involving resident #054. The CIR report indicated that someone had come into resident #054's room and struck identified body areas when care was being provided. The CIR further indicated no injuries were noted but resident #054 had experienced harm. The home conducted an investigation and as a result the staff involved had been disciplined for resident abuse.

In an interview, resident #054 was unable to answer questions regarding the incident.

A review of an assessment completed indicated resident #054's long and short term memory was okay and the resident was able to recall staff names/faces.

In an interview, staff #114 indicated they were told by resident #054 that a staff

member had caused them harm.

A review of the home's investigation notes indicated staff #153 stated that staff #150 would speak inappropriately towards resident #054. Another identified PSW indicated to the home that they could hear from the hallway when staff #150 spoke inappropriately in residents' rooms.

In an interview, staff #150 indicated they had provided care to resident #054 however, denied the allegation of physical abuse towards resident #054, even though they had received a discipline as a result of the home's internal investigation.

In an interview, staff #129 indicated after the home had conducted an investigation, and that staff #150 had been disciplined as a result of physical abuse towards resident #054. [s. 19. (1)] (665)

3. The licensee has failed to ensure that residents were protected from abuse by anyone and not neglected by the licensee or staff in the home.

A Critical Incident Report (CIR) was submitted to the Ministry of Health and Long Term Care (MOHLTC) related to staff to resident abuse.

A review of the CIR indicated resident #037, had reported to staff #147 that staff #150 had entered their room at an identified time and struck them.

A review of the home's investigation notes included a note from staff #147 indicating resident #037 had continued to state that an identified staff member had come into their room and struck them. A review of an assessment completed for resident #037 indicated their memory recall included the ability to recall staff names/ faces. In separate interviews, staff #148 and staff #114 described staff #150's skin tone as described by resident #037.

A review of the schedule/roster for the night shift on an identified date indicated staff #150 had been working on resident #037's resident home area (RHA).

In interviews, staff #147 and staff #129 stated resident #037 was cognitive and lucid when they had reported the incident of alleged abuse. Staff #147 further stated resident #037 was also able to recall the incident to them again the next day. A review of the home's investigation notes also contained a note with a

statement by staff #149 that resident #037 was cognitively well.

In an interview, staff #114 stated resident #037 had reported to them they had discomfort in an identified body area as a result of someone on an identified shift striking them.

Further review of the home's investigation notes contained a letter addressed to staff #150 that stated the home had completed an investigation as a result of an allegation of abuse reported by a resident against staff #150. The letter further indicated that the actions had been substantiated and staff #150 had been disciplined.

In interviews, staff #148 and staff #149 acknowledged striking a resident is considered physical abuse.

In an interview, staff #129 defined physical abuse as any action causing harm to a resident, and stated staff #150 had been disciplined as there were concerns they had provided improper care. [s. 19. (1)]

The severity is actual harm/risk experienced by residents' #037 and #054 and neglect for resident #004. The scope is related to three residents and the previous compliance history indicates a previous non-compliance with LTCH Act,
s. 19 (1) served under report #2016_398605_0021, dated December 13, 2016, with a compliance date of January 23, 2017. Due to actual harm/risk to residents' #037 and #054 and neglect experienced by resident #004 a compliance order is warranted. (673)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 15, 2018

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 13th day of July, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Joanne Zahur

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