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 prévue 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

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jun 03, 2019	2019_654618_0006 (A1)	000036-17, 003281-17, 005407-17, 009506-17, 026932-18, 031372-18, 031829-18, 033447-18	Critical Incident System

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

Amended by CECILIA FULTON (618) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

As Directed by Senior Manager Long-Term Care Inspections Branch, this compliance order has been rescinded.

Issued on this 3 rd day of June, 2019 (A1)

[redacted]

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under *the Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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Fountain View Care Community
1800 O'Connor Drive East York ON M4A 1W7

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

Amended by CECILIA FULTON (618) - (A1)

Amended 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): February 12, 13, 14, 15, 19, 20, 21, 22, 25, 26, 2019.

The following Critical Incident inspection logs were inspected during this inspection:

Log # 003281-17, CIR#2836-000005-17, 009506-17, CIR #2836-000011-17, 000036-17, CIR #2836-000002-17, and #031829-18, CIR #2836-000038-18 related to abuse.

Log # 031372-18, CIR #2836-000037-18, related to falls.

Log # 033447-18, CIR #2836-000041-18 and 005407-17, CIR #2836-000006-17,related to transferring and positioning.

Log # 026932-18, Follow up inspection related to abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Nurse Manager (NM), Registered Staff (RN, RPN), Personal Support Worker (PSW), Residents and Family members.

During the course of the inspection, the inspectors observed staff to resident interaction and reviewed resident health records, relevant policies, home's investigation notes.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of the original inspection, Non-Compliances were issued.
2 WN(s)
1 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	Légende 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 protect resident #10 from abuse by anyone.

On July 13, 2018, a compliance order (CO) #001 was issued as follows:
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. The compliance date was November 15, 2018.

For the purposes of the definition of "neglect" in subsection 2 (1) of the O. Reg. 79/10, "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 the Critical Incident Report # 2836-000041-18, dated December 2018, indicated that resident #010 had an incident that caused an identified injury to the resident.

According to the CIR, PSW #117 reported to the home that they were providing care to resident #010, while resident #010 was in their bed. During the provision of this care, PSW #117 needed to turn the resident from one side to another. While providing this care, an incident occurred resulting in an identified injury to resident #010. The CIR indicated that the PSW demonstrated to the ED and ADOC how this incident occurred, and the conclusion, as identified in the CIR was that no improper care was noted.

A review of resident #010's written plan of care indicated the resident's care

requirements.

Interview with PSW #117 indicated a knowledge of the plan of care. PSW #117 determined that based on the plan of care, they could provide this care to the resident by them selves. During the provision of the care, the PSW stated that the bed was in a high, working height level, and that they had removed an identified safety measure as it was interfering when they were providing care from that side of the bed. The PSW acknowledged that they had failed to return the safety measure into place when they moved to the other side of the bed to provide care. The PSW indicated how the incident causing injury to the resident occurred. The PSW indicated that they had followed the resident's plan of care and that it was okay to provide resident care the way they had. When asked by the inspector if providing resident care in the way they had was safe, the PSW identified that it was not safe.

Interview with PSW #102 and #120, RPN #118, #119, ADOC #103, and DOC indicated that it is not a safe practice to provide care in the manner that it had been provided, and and that PSW #117 should have asked for help to provide care to the resident in order to minimize the resident's safety risk.

The inspectors reviewed the home's Critical Incident investigation notes with the ADOC #103. The investigation notes identify that a re-creation of the incident was undertaken to review what had occurred and that the conclusion of the home's investigation determined that there were no concerns related to staff providing care to the resident.

In an interview, the ADOC confirmed that that conclusion was not correct and confirmed that providing care in the manner described was unsafe and that in performing this action it demonstrated that PSW #117 had a knowledge gap, and that their actions resulted in unintentional neglect.

Interview with the DOC indicated that they had not been part of the investigation into this incident, but that they felt that the way the care was provided was neglectful.

The inspection identified that in the actions of PSW #117 met the definition of neglect, and that the home's original assessment of the incident revealed a lack of knowledge which contributed to putting this resident's safety in jeopardy. [s. 19. (1)]

Additional Required Actions:

(A1)
The following order(s) have been rescinded: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The Licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

This issue was identified for inspection by intake log dated December 2018.

The issue identified in this intake related to an incident that occurred causing an identified injury to resident #010. Interview with PSW#117 identified that at the time of this incident they were providing care to resident #010 and they described how they provided the care. PSW #117 told the inspector that they provided this care without the assistance of any other staff, that the resident's bed was in a high position, and that the safety measure was removed while they were turning the resident. PSW #117 said that they were using one hand to control the residents turn, and the other hand to provide the care when the incident occurred. PSW #117 identified resident #010's cognitive status and that the resident was not able to participate in the activity. PSW #117 told the inspector that providing care in the manner described was okay. Resident #010's plan of care identified the number of staff required to perform tasks identified as bed mobility.

Interview with PSW #116, identified that when they provide care to resident #008 they would often perform the care by themselves, and it may require turning the resident from side to side in their bed. PSW #116 stated that they would provide this care without the assistance of another staff member, and the provision of care may require turning the resident in a particular manner. When asked if this is safe practice, PSW #116 replied that if they felt it was too dangerous, they would call for assistance. Resident #008's plan of care identified the number of staff required to perform tasks identified as bed mobility.

Interview with PSW #121, identified that when they provide care to resident #012, they would often perform this care by themselves, but may call for assistance if the resident was resisting. The delivery of care may require turning the resident in a particular manner. PSW #121, stated that they would put a pillow on the side of the bed to which they were turning the resident. Resident #012's plan of care identified the number of staff required to perform tasks identified as bed mobility.

Interview with DOC revealed that the use of a pillow or blanket to create a barrier when turning a resident was not acceptable and they were not aware of any staff doing this.

Review of the home's investigation into Critical Incident Report concluded that there was no improper procedure noted.

Interview with ADOC and DOC identify that turning a resident in the identified particular manner is never safe and should not be done. [s. 36.]

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 used safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 3 rd day of June, 2019 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by CECILIA FULTON (618) - (A1)
Inspection No. / No de l'inspection :	2019_654618_0006 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	000036-17, 003281-17, 005407-17, 009506-17, 026932-18, 031372-18, 031829-18, 033447-18 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 03, 2019(A1)
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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

(A1)
The following Order(s) have been rescinded:

Order # / Ordre no :	001	**Order Type / Genre d'ordre :**	Compliance Orders, s. 153. (1) (a)

Linked to Existing Order/ Lien vers ordre existant : 2018_630589_0005, CO #001;

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).

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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 3 rd day of June, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by CECILIA FULTON (618) - (A1)

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

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

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