Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 10, 2021	2021_769646_0020	013780-21	Complaint

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 Toronto ON M4A 1W7

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

IVY LAM (646), APRIL CHAN (704759)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 13, 14, 15, 18, 19, 20, 21, 22, and 25, 2021.

The following intake was completed in this Complaint inspection:
Log # 013780-21 related to an allegation of improper care, personal support services, and skin and wound care.

NOTE: The following findings were identified in concurrent inspection #2021_769646_0018 (Complaint Log #005073-21; CIS Log #016451-21, CIS #2836-000023-21) and issued in this report:
- A Written Notification and Voluntary Plan of Correction related to LTCHA, s. 6. (4) was identified for resident #002.
- A Written Notification and Voluntary Plan of Correction related to LTCHA, s. 6. (7) for resident #002.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Assistant Directors of Care (ADOCs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Environmental Services Manager, Housekeeper, Resident Assessment Instrument (RAI) Coordinator, Registered Dietitian (RD), Resident and Family Experience Coordinator, Infection Prevention and Control (IPAC) Lead, Falls Lead, Behavioural Supports Ontario (BSO) Lead, Physiotherapist (PT), Resident and Family Experience Coordinator, Office Manager, Screener, Substitute Decision-Makers, Family Members, Complainants, and Residents.

During the course of the inspection, the inspectors conducted a tour of the home, made observations related to the home's care processes; staff to resident, and resident to resident interactions; conducted reviews of residents' records, and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Personal Support Services

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

- **1 WN(s)**
- **1 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	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. 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident’s care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #002’s transfer sling use, so that their assessment, development and implementation of the resident's plan of care were integrated and were consistent with and complemented each other.

According to resident #002’s care plan and Kardex, the resident was to use one type of transfer sling in the home, and a second type of transfer sling was to be provided in a specific situation.

One Personal Support Worker (PSW) was not aware of the direction to provide the the second transfer sling for the resident in the above specified situation and had not provided the sling to the resident as per the plan of care.

Another PSW indicated the resident should be provided with the second type of sling as noted above. The PSW stated they used the second type of sling in all situations. They were not able to find directions regarding the two different sling types in the resident's care plan.

The Registered Practical Nurse (RPN) indicated that the resident was to be provided with the second type of sling in the above mentioned situation. They also stated that the resident no longer used the first type of sling specified in their care plan, and the care plan should have been updated.

The Physiotherapist (PT) indicated that the resident could not safely use the first type of sling for over a year. The PT indicated that a referral should have been sent to the PT to assess the resident when they were no longer able to use the sling, but no referral was sent.

The Falls Lead / Assistant Director of Care (ADOC) stated it was the nurse's responsibility to notify the PT and to update the care plan, and that this was not done for resident #002.

The Resident Assessment Instrument (RAI) Coordinator indicated the PSWs' Point of Care (POC) care plan was different from the nurses', as the PSWs' care plan did not include interventions for Activities of Daily Living (ADLs) for the resident. Specific directions for sling use and number of staff needed would be found in the resident's Kardex.

The DOC indicated that the staff should have collaborated to assess the resident for the appropriate sling type, and to update the resident's care plan, and this was not done. They were not aware of the differing care plan versions, and expected that PSW staff would be aware of, and provide resident care as per the plan of care.

There was a risk to resident #002's safety when the staff did not collaborate to ensure the resident was reassessed for the appropriate transfer sling they required, and when staff were not aware of where to find directions for the provision of the second type of sling, which was not consistently provided in the above mentioned situation.

[Sources: Record Review of Resident #002's care plan and Kardex, Documentation Survey Report v2, Observations of resident #002 and resident's room; Interviews with the Director of Care (DOC), Physiotherapist (PT), Resident Assessment Instrument (RAI)

Coordinator, Assistant Director of Care, ADOC/Falls Lead, Registered Practical Nurse (RPN), Personal Support Workers, complainant, and other staff.] [s. 6. (4)]

2. The licensee has failed to ensure that the care set out in the plan of care for bed mobility and dressing was provided for resident #002 as specified in the plan.

Resident #002's care plan indicated the resident required two-person assistance for dressing and bed mobility.

A PSW stated they provided one-person assistance to resident #002 for bed mobility and dressing care.

The PT identified resident #002 had health conditions that put them at risk of injury. The PT recommended that resident #002 be provided two-person assistance for dressing and bed mobility per their care plan, as the resident also had behaviours and pain.

The RPN stated that two-person assistance as specified in the resident's care plan was correct for resident #002's bed mobility and dressing. They indicated that there would be a risk for injury if the resident was provided one-person assistance in these activities.

The DOC and ADOC indicated that the PSWs are expected to review both the Kardex and care plan for plan of care. Both identified that two-person assistance, as per the resident's care plan, should be provided to resident #002 for dressing and bed mobility.

There was an increased risk of injury for resident #002 because interventions as specified in the care plan for bed mobility and dressing were not provided.

[Sources: Record Review of Resident #002's care plan; Interviews with the Director of Care (DOC), Physiotherapist (PT), ADOCs, ADOC/Falls Lead, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSWs), and other staff.] [s. 6. (7)]

3. The licensee has failed to ensure that the care in relation to bed mobility and dressing was provided for resident #003 as specified in the plan.

Resident #003's plan of care stated that the resident required two-person assistance dressing, and for bed mobility.

A PSW stated that they provided one-person assistance to resident #003 for dressing and bed mobility. Another PSW and the RN indicated the resident #003 required two-person assistance for dressing and bed mobility.

The PT identified resident #003 at risk for falls, and that they required two-person assistance for dressing and bed mobility, due to their medical diagnoses and risk of injury.

The ADOC indicated care should be provided as specified in the Kardex and the care plan, and that PSWs should review Kardex and care plan documents for information on how to perform activities of daily living. The ADOC stated that resident #003 required two-person assistance for dressing and bed mobility due to their identified care needs. There was an increased risk of injury and fall to resident #003 when interventions as specified in the care plan were not provided.

[Sources: Record Review of Resident #003's care plan; Interviews with the Director of Care (DOC), Physiotherapist (PT), ADOCs, ADOC/Falls Lead, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSWs), and other staff.]
[s. 6. (7)]

4. The licensee has failed to ensure that the care in relation to dressing was provided for resident #004 as specified in the plan.

Resident #004's plan of care indicated the resident required two-person assistance for bed mobility.

A PSW stated that they provided one-person assistance to resident #004 for bed mobility, because the resident was able to participate in the activity.

The RPN indicated that resident #004 required two-person assistance for bed mobility due to their limited mobility and medical diagnosis.

The ADOC indicated that the PSWs should have reviewed both Kardex and care plan for details on resident #004's care needs. The ADOC further stated that two-person assistance should have been provided to resident #004 for bed mobility due to their limited mobility and risk of fall. The RPN and ADOC indicated that the resident required two-person assistance for bed mobility, as specified in their care plan, and this was not provided to the resident.

[Sources: Record Review of Resident #004’s care plan; Interviews with the Director of Care (DOC), Physiotherapist (PT), ADOCs, ADOC/Falls Lead, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSWs), and other staff.]
[s. 6. (7)]

5. The licensee has failed to ensure that resident #004 was reassessed and had their plan of care revised when their falls prevention intervention was no longer needed.

Resident #004’s care plan included the use of a specific falls prevention intervention. The RPN stated that resident consistently refused to use the intervention. The PSW agreed that the resident had not used the intervention for several months.

The RPN indicated resident #004’s care plan included the falls prevention intervention, but that the resident was no longer at risk for falls. They indicated that the resident should have been reassessed and the intervention have been removed and replaced with another.

The ADOC/Falls Lead stated that resident #004 was provided a new assistive mobility device, and since then, their risk of injury from falls was reduced. They further indicated that as the resident had regularly refused to use their falls prevention intervention, the direct care staff could have involved the PT or falls lead to reassess the resident and revise the resident’s care plan related to the use of the falls prevention intervention, but that this was not done.

The DOC stated that the staff should have first educated resident #004 on the intervention, and if the resident continually refused the intervention, the staff should have documented the refusal and revised the care plan. The DOC and ADOC indicated that nursing staff should have involved the Falls Lead for alternative interventions. The DOC indicated that staff were expected to revise the care plan and inform the resident and direct care staff about the changes.

Resident #004’s need for the identified falls prevention intervention was not reassessed and revised by the team when the resident continually refused the use the intervention.

[Sources: Record Review of Resident #004’s care plan and Kardex, Interviews with Physiotherapist (PT), ADOCs, ADOC/Falls Lead, Registered Practical Nurse (RPN),

Personal Support Workers (PSWs), and other staff.] [s. 6. (10) (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:
1) The staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 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;
2) The care set out in the plan of care is provided to the resident as specified in the plan; and
3) The resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

Issued on this 18th day of November, 2021

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

Original report signed by the inspector.