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

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Original Public Report

Report Issue Date September 7, 2022
Inspection Number 2022_1321_0001
Inspection Type
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
2063414 Ontario Limited as General Partner of 2063414 Investment LP

Long-Term Care Home and City
Fountain View Care Community, Toronto

Lead Inspector
April Chan (704759)

Inspector Digital Signature
April W Chan
Digitally signed by April W Chan
Date: 2022.09.13 12:17:21 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 18 – 22, 25, 28, and 29, 2022.

The following intake(s) were inspected:

- #007764-22 (Complaint) related to skin and wound management and alleged neglect

The following **Inspection Protocols** were used during this inspection:

- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION PLAN OF CARE

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 *s. 6 (5)*

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary

A complaint was submitted to the Ministry of Long-Term Care (MLTC) for alleged improper care for the resident leading to worsening of a skin impairment.

The resident had risk factors for skin breakdown including impaired mobility, low body weight, nutritional risk, and a history of skin impairment. The resident developed a skin impairment on a specific date.

Approximately six weeks later, the resident was assessed to have a larger skin impairment. Four days after that assessment, the resident was assessed to have worsening condition of the skin impairment including size and characteristics of the area. The resident was reassessed for moderate daily pain.

Three days after the worsening condition of the skin impairment, a reassessment noted a change that indicated ongoing worsening. The on-call physician of the home was informed, and provided new orders including a wound culture & sensitivity lab test. The resident's substitute decision-maker and power of attorney (POA) was also informed.

The home received lab results four days later, which were reviewed by registered staff who notified the home's physician. Notification of the lab results to the POA was not performed. An Associate Director of Care (ADOC) and Director of Care (DOC) indicated that registered staff were responsible to notify the POA to involve them in the resident's plan of care when the resident's lab results were received.

There was minimal risk to the resident when their SDM was not notified for four days regarding receipt of the lab results. The resident received ongoing treatment and evaluation.

Sources: review of the resident's clinical records and assessments, the home's correspondence with the POA, interviews with complainant, ADOC, DOC and other staff. [s. 6 (5)] (704759)

WRITTEN NOTIFICATION PLAN OF CARE

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 *s. 6 (4) (a)*

The licensee has failed to ensure that registered staff and interdisciplinary team including wound lead collaborated with each other in the assessment of a resident so that their assessments were integrated.

Rationale and Summary

The resident received skin evaluation by the home's wound lead on a specific date. The wound lead indicated that they were not informed by registered staff regarding concerns with the resident's wound culture lab results. The day before, registered staff reviewed lab results on receipt, and then they notified the resident's physician. There was no documentation of the wound lead being notified.

The wound lead indicated that they could not confirm a specific diagnosis without the lab results. The DOC indicated that registered staff were expected to communicate receipt of wound culture lab results amongst each other and to the interdisciplinary team.

There was minimal risk to the resident when registered staff failed to collaborate with the wound lead in the assessment of the resident.

Sources: the resident's clinical records and assessments, the home's correspondence with the POA, interviews with ADOC and DOC. [s. 6 (4) (a)] (704759)

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 *s. 102 (2) (b)*

(i) The licensee has failed to ensure personal protective equipment (PPE) was available and accessible to staff and essential caregivers appropriate to their role and level of risk for Additional Precautions.

The licensee failed to implement measures in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022 (IPAC Standard). Specifically, the licensee did not ensure adequate access of eye protection for staff as required by Additional Requirement 6.1 under the Standard.

Rationale and Summary

On July 18, 2022, at 1136 hours, two staff members were observed not wearing eye protection while providing care for two separate residents on droplet and contact precautions. The required eye protection was not available at point-of-care for staff to access prior to entering the resident rooms.

Both staff members indicated that the additional precautions required PPE gown, gloves, eye protection and masks to be worn prior to entering the room. They said they had accessible supply of PPE, however they had to obtain eye protection from the nursing station. A team member was observed travelling down the end of the hall to obtain eye protection. Both staff members had worn PPE gowns which were accessible outside the resident's doorway.

On, July 18, 2022, at 1407 hours, two PSWs were observed providing care to a resident in their room under droplet and contact precautions. The required PPE eye protection was not worn. An essential caregiver was observed without eye protection after providing care to another resident under droplet and contact precautions. No available supply of eye protection was observed at point of care. A PSW and an RPN indicated that PPE eye protection was out of supply in the home area and was available on request. The next day, the IPAC lead indicated that eye protection was provided to the home areas and that supplies were stored at the nursing stations.

Eye protection reduces the risk of infectious disease transmission to staff member or caregivers of any droplet particles contacting eyes.

Sources: observations, interviews with IPAC lead and other staff members [s. 102 (2) (b)] (704759)

(ii) The licensee has failed to ensure Additional Precautions were followed including the proper use of PPE, including appropriate selection, application, removal, and disposal.

The licensee failed to implement measures in accordance with the IPAC Standard. Specifically, the licensee did not ensure Additional Precautions are followed in the IPAC program by Additional Requirement 9.1 under the Standard.

Rationale and Summary

According to the home's policy for putting on PPE starts with hand hygiene prior to putting on gown, mask, eye protection and gloves.

On July 18, 2022, at 1136 hours, an RPN was observed not performing hand hygiene prior to putting on PPE gown and gloves prior to entering a resident's room on droplet and contact precautions. The RPN acknowledged that hand hygiene should be performed before putting on PPE and that eye protection was also required to be worn prior to entering the resident's room.

A staff member was observed inside a resident's room on droplet and contact precautions wearing only mask and gloves. They acknowledged that gown, mask, eye protection and gloves were all required to be worn prior to entering the resident's room but had not been aware of the additional precautions.

As mentioned above, on July 18, 2022, at 1407 hours, two PSWs were observed providing care to a resident under droplet and contact precautions without eye protection. Another essential caregiver was observed without eye protection after providing care to another resident under droplet and contact precautions.

The essential caregiver was observed exiting a resident's droplet and contact isolation room, without removing their gown and gloves, traversing down the hall to dispose soiled linen and garbage. The essential caregiver indicated that they usually take out the garbage first prior to removing and disposing their PPE. An RPN indicated that removal of PPE should have been performed prior to taking out the soiled linens and garbage down the hall.

There was a risk of infectious disease transmission when Additional Precautions were not followed.

Sources: the home's policy Recommended steps for putting on and taking off personal protective equipment (PPE), policy #IX-G-10.20(b) revised April 2019, observations, interviews with IPAC lead, staff members and other caregivers. [s. 102 (2) (b)] (704759)

(iii) The licensee has failed to ensure to point-of-care signage indicating enhanced IPAC control measures were in place.

The licensee failed to implement measures in accordance with the IPAC Standard. Specifically, the licensee failed to ensure point-of-care signage indicating droplet and contact precautions were in place as required by Additional Requirement 9.1 under the Standard.

Rationale and Summary
According to the home's policy on identification of isolation rooms, any resident placed on additional precautions will have this information communicated to team members. Specific information could be placed on the resident's door indicating the type of additional precautions in place.

As mentioned above, on July 18, 2022, at 1116 hours, a staff member was observed inside a resident's room without the full required PPE. The resident's door was observed with point-of-care signage stating droplet and contact additional precautions.

During medication administration, an RPN was observed entering a resident's room wearing PPE where there was no point-of-care signage. The RPN indicated that the resident was under droplet and contact precautions, the signs were posted in the morning, however other residents with behaviours sometimes removed the point-of-care signs.

The IPAC lead indicated that there is a risk of infectious disease transmission when point-of-care signage was not posted up on the door to alert staff and that staff should check with the nurse on the unit prior to providing care.

Sources: the home's policy on Identification of Isolation Rooms, policy # XXII-G-20.00, revised December 2020), observations, interviews with IPAC lead and other staff members [s. 102 (2) (b)] (704759)

WRITTEN NOTIFICATION ADMINISTRATION, MISCELLANEOUS

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 *s. 184 (3)*

The licensee has failed to comply with Minister's Directive: COVID-19 response measures for long-term care homes, effective April 27, 2022, when an essential visitor did not wear a medical mask for the entire duration of their visit indoors including the resident's room.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, effective April 27, 2022, the licensee was required to ensure that masking requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, effective June 28, 2022 were followed. Specifically, the licensee did not ensure that general or essential visitors wore a medical mask for the duration of their visit and removal of masks for the purposes of eating should be restricted to areas designated by the home.

Rationale and Summary

On July 18, 2022, at 1153 hours, an essential caregiver was observed eating in a resident's room with the resident present. An RPN indicated that after speaking with them, the essential caregiver acknowledged that they should have taken their snack to a designated area in the home away from residents. The IPAC lead indicated that essential caregivers have dedicated break rooms to eat and should not have done so in front of the resident.

Sources:

COVID-19 guidance document for long-term care homes in Ontario Updated: June 28, 2022, observations, interview with IPAC lead and other staff [s. 102 (7) 11] (704759)

COMPLIANCE ORDER [CO#01] INFECTION PREVENTION AND CONTROL PROGRAM

NC#05 Compliance Order pursuant to FLTCA, 2021, s.154(1)2

Non-compliance with: O. Reg. 246/22 *s. 102 (7) 11*

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The licensee has failed to comply with **O. Reg. 246/22 *s. 102 (7) 11***

The licensee shall:

(1) Conduct random meal audits to ensure direct care staff compliance with the home's hand hygiene policy for a period of one month following the service of this order.
(2) Maintain a record of the audits, including the date, who conducted the audit and actions taken in response to the audit findings.

Grounds

Non-compliance with: O. Reg. 246/22 *s. 102 (7) 11*

The licensee has failed to ensure residents were supported to perform hand hygiene prior to receiving meals.

The licensee failed to implement measures in accordance with the IPAC Standard. Specifically, the IPAC lead failed to implement a hand hygiene program that ensure residents are supported to perform hand hygiene prior to receive meals and snacks as required by Additional Requirement 9.1 under the IPAC Standard.

Rationale and Summary
According to the home's hand hygiene policy, hand hygiene practices consist of either hand washing with soap and water or the use of alcohol-based hand rub (ABHR). Residents may use ABHR prior to eating or group activities. The IPAC lead also indicated that hand wipes could be used for residents' hand hygiene prior to every meal.

On July 18, 2022, at 1212 hours, two PSWs was observed assisting two residents in wheelchairs to the dining room tables. The residents were not assisted with hand hygiene. Another PSW and IPAC lead both indicated that PSWs were responsible to support residents who require assistance with hand hygiene prior to meals.

Another resident in a wheelchair was observed to self propel using their hands. After self-propelling to a dining room table, there was no assistance offered to the resident for hand hygiene. The IPAC lead indicated that an assigned PSW was expected to bring hand sanitizing wipes and hand sanitizers for residents who can sanitize themselves.

An RPN was observed assisting two residents in wheelchairs to the dining room tables. There was no assistance offered to the residents for hand hygiene. One of the residents identified the hand wipes and foam dispensers in the dining room area that were used for resident's hand washing. However, they noted that they were seldom assisted with hand hygiene prior to meals.

There was a risk for infectious disease transmission when residents were not supported to perform hand hygiene prior to meals.

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Sources: the home's policy on Hand Hygiene, policy # IX-G-10.10, revised December 2021, observations, interview with residents, ED, IPAC lead and other staff. [s. 102 (7) 11] (704759)

This order must be complied with by October 14, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.