Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
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Original Public Report

Report Issue Date: April 14, 2023
Inspection Number: 2023-1321-0003
Inspection Type: Critical Incident System
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP
Long Term Care Home and City: Fountain View Care Community, Toronto

Lead Inspector	**Inspector Digital Signature**
Parimah Oormazdi (741672)	Parimah Oormazdi Digitally signed by Parimah Oormazdi Date: 2023.04.17 13:14:52 -04'00'

Additional Inspector(s)
Cindy Cao (000757) was present during this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 27-31, 2023

The following intake(s) were inspected:
- Intake: #00021767 was related to falls prevention and management.
- Intake: #00021780 related to prevention of abuse and neglect.

The following intakes were completed in the Critical Incident System Inspection:
- Intake: #00018012 was related to falls prevention and management.
- Intake: #00020001 was related to falls prevention and management.

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee failed to ensure that a resident's written plan of care sets out clear directions to staff regarding a timeframe of when an intervention should be applied for the resident.

Rationale and summary:
A physical altercation occurred between two residents. As a result of this incident, one of the two residents had injuries and was transferred to hospital for further assessment.

One of the resident's clinical records indicates that they had history of responsive behaviours and required specific interventions applied for the resident, however, the timeframe of when this intervention was to be applied was not specified.

Through an interview with a Registered Practical Nurse (RPN) and Personal Support Worker (PSW), discrepancies were identified about their knowledge of when this intervention was to be applied for the resident and whether it should have been in place at the time of the above mentioned incident or not. The Behaviour Support Ontario (BSO) lead and Resident Assessment Instrument (RAI) coordinator both confirmed that a clear direction should have been provided in resident's care plan about the intervention timeframe to ensure residents' safety.

Failure to provide clear direction to staff about the timeframe that an intervention should be applied for the resident, has put the other resident at risk of physical abuse and injuries.

Sources: Clinical records review of the two residents, interview with RPN, PSW, RAI coordinator and BSO lead.
[741672]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (11) (b)

The licensee failed to ensure that different approaches are considered in the revision of resident's plan of care related to falls, specifically when a fall prevention intervention was identified to been not effective.

Rationale and Summary:
A resident had a fall when they were attempting to go for toileting. Following the fall incident, they were transferred to the hospital and sustained a significant change to their condition.

The Long-Term Care Home (LTCH)'s policy and procedure "Falls Prevention and Management - VII-G-30.10", last revised December 2021, indicates that " The preventative interventions should be monitored and their effectiveness should be evaluated on an ongoing basis and with the quarterly review."

The resident's clinical records indicates that they were at risk for falls and had fall prevention interventions added in their plan of care. However, the fall prevention intervention was not effective for the resident. There were no records identified to reassess the resident's fall prevention interventions for their effectiveness and take different approaches if they are not effective. Their care plan also indicates that they require a level of assistance for toileting.

The PSW indicated that staff were not aware of the resident's level of assistance for toileting and effectiveness of their fall prevention intervention. The Director of Care (DOC) confirmed that the effectiveness of the fall prevention device should have been re-assessed and replaced with another fall prevention intervention which could have been more helpful for the resident.

Failure to reassess the effectiveness of fall prevention interventions and taking different approaches in the revision of the resident's plan of care related to falls lead to an increased risk for falls.

Sources: CI report, the resident's clinical records, interview with PSW and DOC, Falls Prevention and Management - VII-G-30.10", last revised December 2021.
[741672]

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee failed to ensure that a resident was protected from physical abuse by another resident.

Section 2 (1)(c) of Ontario Regulations 246/22 defines "Physical abuse" as the use of physical force by a resident that causes physical injury to another resident.

Rationale and summary:
A resident had a physical interaction with another resident. As a result, one of the two residents got injured and was transferred to the hospital for further assessment.

The DOC acknowledged that the resident experienced physical abuse by the other resident.

Failure to protect the resident from physical abuse, resulted in injuries and a transfer to the hospital.

Sources: Residents' clinical records, interview with BSO lead, RPN and DOC, CI report.
[741672]

WRITTEN NOTIFICATION: CONTINENCE CARE AND BOWEL MANAGEMENT

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (c)

The licensee failed to ensure that assistance was provided to a resident who was unable to toilet independently sometimes and required toileting assistance.

Rationale and summary:
A resident who required a level of toileting assistance, was not toileted for certain period of time. As a result, they attempted to go for toileting independently and fell which caused severe injury.

The home's policy and procedure "Continence Program - Promoting Continence, VII-D-10.10", last revised April 2019, indicates that "According to specified timeframes, all Care Team Members will remind the resident that it is time to go to the bathroom and provide toileting assistance as specified in their plan of care."

Resident's care plan indicates that they require a level of assistance for toileting.

The PSW indicated that they were not aware that the resident required assistance for toileting and they did not remind the resident to go to the washroom. The DOC confirmed that assistance should have been provided to the resident if it is indicated in their care plan.

Failure to provide toileting assistance for the resident put them at risk of a fall and injury.

Sources: Resident's clinical records, interview with DOC and PSW, Continence Program Policy - Promoting Continence, VII-D-10.10", last revised April 2019.
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