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
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: July 26, 2023

Inspection Number: 2023-1321-0004

Inspection Type:
Complaint
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: 2023.08.02 16:00:31 -04'00'

Additional Inspector(s)
Colleen Lewis (Training Specialist) was also present during this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 10-13, 2023.

The following intake(s) were inspected:

- Intake: #00091111 was related to unknown cause of injury.
- Intake: #00091139 was related to unknown cause of injury.

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

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Minimizing of Restraining

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 36 (3)

The licensee has failed to ensure that a resident 's plan of care was revised when their locomotion needs changed and they required a mobility equipment as a Personal Assistance Services Device (PASD).

Rationale and Summary
A complaint was submitted to the Long Term Care Home (LTCH) and the Director related to a resident's unknown cause of injury. The resident was re-assessed later to have a mobility equipment for locomotion. However, their care plan was not revised and updated with the change in their locomotion and the provided mobility equipment.

The Physiotherapist (PT) indicated that a mobility equipment used by this resident was considered as PASD should have been added in the resident's care plan. The Associate Director of Care (ADOC) who was also the home's falls lead acknowledged that the resident's care plan was not revised when they were re-assessed for locomotion and the mobility equipment was provided to them. The Director of Care (DOC) indicated that residents' care plan is the main source for staff members to be informed about residents' care needs and the resident's locomotion care plan should have been revised and updated to address the mobility equipment as PASD.

Failure to revise the resident's care plan when they required PASD put them at increased risk of injury.

Sources: The resident's clinical records and care plan, interviews with the PT, ADOC and the DOC [741672]