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

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Original Public Report

Report Issue Date: March 27, 2024
Inspection Number: 2024-1321-0001
Inspection Type: Proactive Compliance Inspection
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP
Long Term Care Home and City: Fountain View Community, Toronto

Lead Inspector	**Inspector Digital Signature**
Kehinde Sangill (741670)	Kehinde Sangill Digitally signed by Kehinde Sangill Date: 2024.04.16 11:40:54 -04'00'

Additional Inspector(s)
Ramesh Purushothaman (741150)
Arther Chandramohan (000720)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 16, 20-23, 26, 27, 29, 2024 and March 1, 4, 5, 2024

The following intake(s) were inspected:

- Intake: #00109053 - Proactive Compliance Inspection

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

Medication Management
Food, Nutrition and Hydration
Safe and Secure Home
Quality Improvement
Pain Management

Falls Prevention and Management
Resident Care and Support Services
Skin and Wound Prevention and Management
Residents' and Family Councils
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care related to a dietary intervention.

Rationale and Summary

A resident required a specific feeding strategy to improve their food intake. The resident's care plan did not provide clear direction to staff on the feeding strategy.

Staff were observed feeding the resident without implementing the recommended feeding strategy. A Personal Support Worker (PSW) who fed the resident acknowledged that they did not understand the direction provided in the resident's care plan related to the feeding strategy.

The Registered Dietitian (RD) acknowledged that the direction provided to staff was unclear and immediately updated the care plan to clarify.

There was risk that staffs' inability to follow recommended feeding strategy for the resident may impact their intake.

Sources: Observations; resident's clinical records; interviews with staff.
[741670]

Date Remedy Implemented: February 23, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 102 (7) 11.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
11. Ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care. O. Reg. 246/22, s. 102 (7).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) lead carried out their responsibilities related to the hand hygiene program.

The IPAC lead failed to ensure that there was in place a hand hygiene program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes April 2022" (IPAC Standard). Specifically, the IPAC lead failed to ensure that the hand wipes used for assisting residents to perform hand hygiene before meals included 70-90% Alcohol-Based Hand Rub (ABHR) as required by Additional Requirement 10.1 under the IPAC standard.

Rationale and Summary

A PSW was observed assisting residents with hand hygiene prior to lunch using Purell alcohol hand wipes with 62% alcohol content.

The PSW acknowledged that Purell wipes were used for residents who required total assistance with meals. They indicated that residents who were independent with meals used ABHR with 70% alcohol for hand hygiene.

The IPAC lead confirmed that 62% alcohol wipes were sent to the dining room in error and were removed as soon as the error was identified.

There was low risk to residents as the Purell wipes were used for residents who required total feeding assistance.

Sources: Observations; review of "Purell alcohol hand wipe" label and IPAC Standard for Long-Term Care Homes (LTCHs), dated April 2022 (revised September 2023); interviews with staff.
[741670]

Date Remedy Implemented: February 20, 2024

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

The licensee has failed to ensure that the residents' right to be afforded privacy in treatment was fully respected and promoted.

Rationale and Summary

A Registered Nurse RN was observed providing treatment to residents in a common area.

The RN acknowledged that they did not afford the residents privacy in treatment.

The home's policy directed nursing staff to ensure that privacy measures were always in place during treatment in a manner and location that was respectful of the resident's privacy.

There was low risk and impact to the residents when treatment was not provided in privacy.

Sources: Observations; a review of the home's policy revised June 30, 2023; and interviews with staff.
[741670]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that the care set out in the plan of care was provided to residents as specified in the plan.

Rationale and Summary

1) A resident required their bed to be positioned at the lowest height to reduce the risk of fall-related injury.

The resident's bed was not at the lowest height while they were in bed.

A PSW acknowledged that they assisted the resident to bed but failed to lower bed height.

Failure to ensure the bed was at the lowest height while the resident was in bed increased the risk of fall-related injury.

Sources: observation; review of resident's clinical records; and interview with staff. [000720]

Rationale and Summary

2) A resident required a specific falls intervention to alert staff in the event of a fall. The resident was observed without the intervention on one occasion. A PSW verified that the intervention had not been applied as specified in the resident's plan of care.

Failure to ensure that the resident's falls intervention was in place put the resident at risk of not receiving timely intervention in the event of a fall.

Sources: observation; review of resident's clinical record; and interview with staff. [000720]

Rationale and Summary

3) A resident required the application of an intervention to minimize the risk of fall related injuries. The resident was observed without the intervention on one occasion.

A PSW acknowledged that they did not follow the resident's plan of care when they did not apply the intervention.

Failure to ensure the resident was provided with care as set out in their plan of care, placed the resident at risk of injury.

Sources: Observations; review of resident's clinical records; interviews with staff. [741670]

WRITTEN NOTIFICATION: Accommodation Services

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has failed to ensure that the wall in a resident's room was maintained in a safe condition and good state of repair.

Rationale and Summary

The inspector observed a hole in the wall of a resident's room. A family member made it known that the hole had been there for over a month.

A RN noted that there were no records that the damage was reported to the maintenance department. The Director of Environmental Services (DES) confirmed that they had not received a referral about the damage prior to inspector's observation. They acknowledged the hole in the wall should have been reported to the maintenance department for immediate repair.

Failure to maintain the home in safe condition and in a good state of repair put the resident and staff at risk of injury and may have impacted the resident's quality of life.

Sources: Observation; and interviews with staff.
[741670]

WRITTEN NOTIFICATION: IPAC Program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 23 (2) (a)
Infection prevention and control program
s. 23 (2) The infection prevention and control program must include,
(a) evidence-based policies and procedures;

The licensee has failed to comply with the evidence-based policies which were a component of the home's IPAC program.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that the IPAC program included evidence-based policies and procedures and must be complied with.

Specifically, staff did not comply with the policy "Dress Code- Additional Precautions", revised April 2019, which was included in the licensee's Infection prevention and control program.

Rationale and Summary

A Registered Practical Nurse (RPN) was observed with long artificial nails on the fingers of both hands.

The RPN confirmed they were wearing artificial nails and acknowledged that they should not be worn while providing care for residents in the home.

The Director of Care (DOC) confirmed that staff should not wear artificial nails in the home as it does not align with the home's policy and interferes with effective hand hygiene.

The home's policy stated that false nails and nail extensions should not be worn by team members providing care to residents as they have been proven to harbour microorganisms.

Wearing artificial fingernails may impact the effectiveness of staff's hand hygiene practices.

Sources: Observation; review of the home's Dress Code – Additional Precautions policy (Version IX-C-10.10: revised April 2019); and interviews with staff. [741670]

WRITTEN NOTIFICATION: Training

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)
Training
s. 82 (4) Every licensee shall ensure that the persons who have received training under

subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The licensee has failed to ensure that the persons who received training for zero tolerance of abuse and neglect received retraining annually.

Rationale and Summary

The home's training record on abuse prevention showed that 15 staff members did not complete the required training in 2023.

The DOC acknowledged that 14 of the staff who still worked in the home did not complete annual training on abuse and neglect in 2023.

Failure to provide annual training on abuse prevention for front line staff may impede their ability to adequately identify and address potential abuse of residents.

Sources: Review of "RELIAS-Abuse and Neglect" course completion record from January 1, 2023, to December 31, 2023; and interview with DOC.
[741670]

WRITTEN NOTIFICATION: Directives by Minister

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The Licensee failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, when masking requirements were not followed by a PSW and an Environmental Staff.

Rationale and Summary

In accordance with the Minister's Directive: COVID -19 response measures for long-term care homes, effective August 30, 2022, and the COVID-19 guidance document for long-term care homes in Ontario, updated November 7, 2023; masks were required indoors in all resident home areas (RHAs).

An environmental staff and a PSW were observed on RHAs with their masks under their chin.

The environmental staff acknowledged that they did not wear their mask as required while in the RHA. The PSW acknowledged that they did not wear their mask because they were not providing direct care to residents.

The IPAC lead confirmed that masking was required at all times in the RHAs.

The home's masking policy directed staff to always comply with masking requirements even when not delivering direct care.

Staff's failure to don surgical masks in RHAs in accordance with the directives at the time increased the risk of transmission of infection to residents and other staff.

Sources: Observation; Minister's Directive: COVID-19 Response Measures for Long-Term Care Homes, COVID-19 Guidance Document for Long-Term Care Homes in Ontario updated November 7, 2023, and the home's Continuous Masking Policy IX-N-10.48 (revised November 2023); and interviews with staff.
[741670]

WRITTEN NOTIFICATION: Doors in a Homes

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that doors leading to non-residential areas were kept closed and locked when not supervised by staff.

Rationale and Summary

Doors leading to the Linen storage rooms on two RHAs, and the clean utility room on one RHA were left unlocked and unsupervised. The rooms contained various items including personal hygiene products and medical supplies.

Staff acknowledged that the Linen storage and clean utility rooms were non-residential areas and should have been locked to ensure resident safety.

Failure to secure non-residential areas put residents at risk of accessing unsupervised areas of the home.

Sources: Observations; home's Door Lock - Rekeying & Security policy (V-C-30.40, Last updated July 2017); interviews with staff.
[741670]

WRITTEN NOTIFICATION: Bathing

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the

home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that a resident was bathed, at a minimum, twice a week by the method of their choice.

Rationale and Summary

A resident's care plan indicated that showers were their preferred bathing method for which they were scheduled twice a week.

The resident confirmed that they had not received a shower in more than four months.

A PSW and RN confirmed that the resident had been offered sponge baths on their shower days because the home did not have the required equipment for the resident's shower.

The DOC acknowledged that they were unaware that the resident did not have the required equipment for a shower and had not received a shower in four months.

Failure to provide showers to the resident per their preference may negatively impact their hygiene.

Sources: Resident's clinical records; and interviews with a resident and staff. [741670]

WRITTEN NOTIFICATION: IPAC Program

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program

s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

(i) The licensee has failed to ensure that Routine Practices and Additional Precautions were followed in the IPAC program related to hand hygiene.

The licensee has failed to ensure that Routine Practices were in accordance with the IPAC Standard. Specifically, hand hygiene as required by Additional Requirement 9.1 (b) under the IPAC Standard.

Rationale and Summary

(a) A PSW provided care to a resident, and without performing hand hygiene, immediately assisted another resident. The PSW acknowledged that hand hygiene was missed prior to assisting the second resident.

On the same day, another PSW assisted another resident in their room and did not perform hand hygiene upon exiting the room. The PSW acknowledged that they were unaware that hand hygiene was required after resident and environment contact.

The following week, another PSW was observed entering a resident's room without performing hand hygiene. The PSW acknowledged that they should have performed hand hygiene before entering the resident's room.

The IPAC lead acknowledged that hand hygiene must be completed at the four moments of hand hygiene in accordance with the home's hand hygiene policy.

Failure by the direct care staff to perform hand hygiene before and after resident and environment contact increased the risk of disease transmission.

Sources: Observations; Review of the home's hand hygiene policy (Hand Hygiene IX-G-10.10 last revised 11/2023), and IPAC Standard for Long-Term Care Homes

(LTCHs), dated April 2022 (revised September 2023); Interviews with staff.
[000720]

Rationale and Summary

(b) On another occasion a PSW was observed wearing disposable gloves and carrying soiled clothing from a resident's room to the laundry. The PSW entered the door code, dropped the laundry down the chute and wheeled a dirty linen cart from one RHA to another while wearing the same pair of gloves.

The PSW acknowledged that they forgot to remove the used gloves and perform hand hygiene before moving from one RHA to another.

Staff's failure to follow proper hand hygiene practice before moving between units increased the risk of spreading infections in the home.

Sources: Observations; IPAC Standard for Long-Term Care Homes (LTCHs), dated April 2022 (revised September 2023); interviews with staff.
[741670]

(ii) The licensee has failed to ensure that staff used Personal Protective Equipment (PPE) in accordance with Routine Practices and Additional Precautions.

The licensee failed to ensure that additional precautions were followed in accordance with the IPAC Standard. Specifically, the licensee did not ensure the proper use of PPE, including appropriate selection and application as required by Additional Requirement 9.1 (f) under the IPAC Standard.

Rationale and Summary

A PSW was observed providing direct care to a resident on additional precautions without wearing the required PPE indicated by the signage on the resident's door.

The PSW stated they were unaware the resident was on additional precautions. The IPAC lead acknowledged that the signage on the door should have been followed for PPE use.

Failure to adhere to the PPE requirements while providing direct care to a resident on additional precautions increased the risk of disease transmission within the home.

Sources: Observation; signage posted on a resident's door, and IPAC Standard for Long-Term Care Homes (LTCHs), dated April 2022 (revised September 2023); interviews with staff.
[000720]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 5.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
5. The home's registered dietitian.

The licensee has failed to ensure that the Continuous Quality Improvement (CQI) committee included the home's RD.

Rationale and Summary

The Quality Improvement (QI) meeting minutes listed the team members who were part of the CQI committee. The home's RD was not included in the list.

The DOC acknowledged that the home's RD was not a member of the home's CQI committee.

Failure to include the Dietitian in the CQI committee was a missed opportunity to obtain relevant interdisciplinary feedback to assist the homes in their CQI initiatives.

Sources: CQI committee meeting minutes (March 31, 2023, and July 27, 2023), interviews with the DOC.
[741670]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 6.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
6. The home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider.

The licensee has failed to ensure that the CQI committee included the home's pharmacy service provider.

Rationale and Summary

The QI meeting minutes listed the team members who were part of the CQI committee. The home's pharmacist was not included in the list.

The DOC acknowledged that the pharmacist was not a member of the home's CQI committee.

Failure to include the pharmacist in the CQI committee was a missed opportunity to obtain relevant interdisciplinary feedback to assist the homes in their CQI initiatives.

Sources: CQI committee meeting minutes (March 31, 2023, and July 27, 2023), interviews with the DOC.
[741670]

WRITTEN NOTIFICATION: Additional Training — Direct Care Staff

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 1.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.

The licensee has failed to ensure that all staff who provided direct care to residents received annual training in falls prevention and management as required under s. 82 (7) of the Act.

Rationale and Summary

Pursuant to O. Reg. 246/22 s. 260 (1), the home was required to provide all direct care staff annual training in falls prevention and management.

The home's training record on understanding falls showed that 16 staff members did not complete the required training in 2023.

The DOC acknowledged that 12 of the staff who did not complete the falls prevention and management training in 2023 still worked in the home.

Failure to provide annual retraining on falls may impede staffs' ability to follow proper protocol after residents fall and monitor the effect of interventions implemented to prevent falls.

Sources: Review of "RELIAS- Understanding falls" course completion record from January 1, 2023, to December 31, 2023; and interview with DOC.
[741670]

WRITTEN NOTIFICATION: Additional Training — Direct Care Staff

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 2.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care.

The licensee has failed to ensure that all staff who provided direct care to residents received annual training in skin and wound care as required under s. 82 (7) of the Act.

Rationale and Summary

Pursuant to O. Reg. 246/22 s. 260 (1), the home was required to provide all direct care staff annual training in skin and wound care.

The home's training record on skin and wound care showed that 13 staff members did not complete the required training in 2023.

The DOC acknowledged that 12 of the staff who did not complete the skin and wound training in 2023 still worked in the home.

Failure to provide annual training on skin and wound care to staff may compromise staff's ability to follow proper protocol when they identify residents with skin impairment.

Sources: Review of "RELIAS- Skin and wound care" course completion record from January 1, 2023, to December 31, 2023; and interview with DOC.
[741670]

WRITTEN NOTIFICATION: Additional training — direct care staff

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 4.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain.

The licensee has failed to ensure that all staff who provided direct care to residents received annual training in pain management as required under s. 82 (7) of the Act.

Rationale and Summary

Pursuant to O. Reg. 246/22 s. 261, the home was required to provide all direct care staff annual training in Pain Management.

The home's training record showed that 17 of 78 PSWs who currently worked in the home did not complete the annual Pain Management refresher.

The Training Lead acknowledged that all direct care staff should have completed 2023 refresher training for pain management.

Failure to ensure staff completed annual Pain Management training increased the risk of pain not being managed appropriately for residents.

Sources: Review of "RELIAS- Pain Management" course completion record from January 1, 2023, to December 31, 2023; and interview with staff.
[000720]

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