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: May 13, 2024

Inspection Number: 2024-1321-0002

Inspection Type:
Complaint
Critical Incident

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**
Carole Ma (741725)	Hui - Chia Carole Ma Digitally signed by Hui - Chia Carole Ma Date: 2024.05.22 12:25:45 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 22, 23, 25, 26, 29, 30, May 1, 2, 2024.

The following Critical Incident (CI) intake(s) were inspected:

- Intake: #00107576 - [CI 2836-000004-24] - Related to disease outbreak
- Intake: #00112307 - [CI 2836-000006-24] - Related to a fall resulting in a significant change to health condition

The following Complaint intake(s) were inspected:

- Intake: #00109795 - Related to improper/incompetent transfer, resident-to-resident abuse and power of attorney
- Intake: #00113122 - Related to improper/incompetent care

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Stephanie Irwin was onsite April 22, 2024, for this inspection.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Reporting and Complaints
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 (8)
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee has failed to ensure a Personal Support Worker (PSW) reviewed a resident's care plan before providing direct care.

Rationale and Summary
An Essential Caregiver (EC) found a resident alone in their room at risk of harm. Upon calling for assistance, a Registered Nurse (RN) removed the risk.

The home's policy related to plan of care indicated PSWs were to access the plan of care for each resident they were providing direct care for. The PSW indicated they accessed the plan of care by reviewing the care plan.

The PSW acknowledged they were unfamiliar with the resident and did not review the resident's care plan before providing direct care. The resident's care plan identified risks associated with the direct care provided.

Failure to review the care plan prior to providing direct care placed the resident at risk of harm.

Sources: Resident's clinical records, home's policy related to plan of care, Interviews with an RN and PSW. [741725]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure an incident of incompetent care for a resident was immediately reported to the Director.

Rationale and Summary
An EC found a resident alone in their room at risk of harm. Upon calling for assistance, an RN removed the risk.

Two days later, an area of concern appeared on a specific location of the resident's body which the EC suspected was related to the incident and reported their suspicion to a second RN.

The Director of Care (DOC) was aware of the home's internal investigation findings and acknowledged the resident was placed at risk for harm. They also confirmed the incident was not reported to the Director.

Failure to immediately report this incident of incompetent care to the Director placed the resident at risk for delayed follow up actions.

Sources: Resident's clinical records, home's investigation notes, Interviews with RNs and DOC. [741725]

WRITTEN NOTIFICATION: NUTRITIONAL CARE AND HYDRATION PROGRAMS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(c) the implementation of interventions to mitigate and manage those risks.

The licensee has failed to ensure that a resident was provided with safe direct care.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies and protocols were developed for nutritional care and dietary services to ensure resident dining needs and requirements were met.

Specifically, a PSW did not comply with the home's dining experience policy which was included in the home's nutritional care and hydration program.

Rationale and Summary
An EC found a resident alone in their room at risk of harm. Upon calling for assistance, an RN removed the risk.

The PSW indicated they spent a specific amount of time providing direct care to the resident and acknowledged they did not check the resident for risks associated with the direct care before leaving them alone in their room.

The RN indicated that the regular PSW assigned to the resident's care would require more time to complete the same task.

The home's policy required PSWs to allow residents sufficient time to complete this type of direct care, to monitor residents for specific associated risks and to report any incidents to the nurse.

Failure to ensure the PSW complied with the home's dining experience policy placed the resident at risk for harm.

Sources: Resident's clinical records, home's policy on dining experience, Interviews with an RN and PSW. [741725]

WRITTEN NOTIFICATION: HAZARDOUS SUBSTANCES

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

The licensee has failed to ensure cleaning solutions used in the home were kept in a locked housekeeping cart when the cart was left unattended on a specific unit.

Rationale and Summary
A housekeeping cart was observed in the hallway of a specific unit, while a Housekeeper (HSK) was in the resident lounge cleaning the floors with their back to the cart. Residents were in the adjacent room for meal service. The HSK showed the Inspector that various hazardous cleaning solutions were stored in an unlocked compartment of the cart.

The HSK and the Director of Environmental Services (DES) confirmed only supervisors had keys to the compartment on housekeeping carts where cleaning solutions were stored. They acknowledged the potential risk to residents if they were to come into contact with a cleaning solution.

The home's housekeeping cart policy indicated that the HSK would ensure the housekeeping cart was locked at all times when not attended.

Failure to ensure the home complied with its housekeeping cart safety policy exposed residents to risk from contacting or ingesting hazardous cleaning solutions.

Sources: Observations, home's housekeeping cart policy, cleaning solution product

labels, Interviews with a HSK and DES. [741725]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure symptoms of an infectious disease were recorded every shift for a resident.

Rationale and Summary
A resident tested positive for an infectious disease on two specific dates and was placed on isolation for a period of time. During this time, the home failed to record their symptoms in the home's documentation system for two shifts.

A Registered Practical Nurse (RPN) and the IPAC lead/ADOC confirmed the missing documentation of monitoring this resident for symptoms of infection.

Failure to ensure the resident's symptoms of infection were recorded every shift placed them at risk for team members not being made aware of a potential change in condition.

Sources: Resident's clinical records, Line list for outbreak, Interviews with an RPN and IPAC lead/ADOC. [741725]

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WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

The licensee has failed to ensure a complainant was provided with the contact information for the Ministry of Long-Term Care (MLTC) and the Patient Ombudsman.

Rationale and Summary
An EC found a resident alone in their room at risk of harm. Upon calling for assistance, an RN removed the risk. Two days later, an area of concern appeared on a specific location of the resident's body which the EC suspected was related to the incident.

The EC spoke with a second RN about this incident and the area of concern on two separate days. They expressed concern related to the care provided.

The IPAC lead/ADOC and DOC indicated they did not consider this a complaint. The IPAC lead/ADOC, however, documented the home's internal investigation on a complaints form and included "Family Complaint" in the document title. They also wrote that the EC made a verbal complaint to staff on a specific date. The DOC

acknowledged the concern raised by the EC was related to resident care and that the EC was not happy.

The IPAC lead/ADOC and the DOC confirmed the EC was not provided with contact information to the MLTC and the Patient Ombudsman to report this complaint.

The home's complaint management policy indicated that for verbal complaints that required more than 24 hours for resolution, the complainant would receive a written response that included MLTC's toll-free number for making complaints and its hours of service, and the contact information for the Patient Ombudsman.

Failure to ensure the home complied with its complaints policy resulted in the EC not being made aware of additional resources that provided oversight to resident care.

Sources: Resident's clinical records, home's investigation notes, home's complaints policy, Interviews with an RN, IPAC lead/ADOC and DOC. [741725]