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: October 17, 2024.

Inspection Number: 2024-1321-0004

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 8-11, 2024.

The below follow-up intakes were inspected on:

- Intake #00121890 related to fall prevention and management.
- Intake #00121891 related to infection prevention and control.

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

- Intakes #00121908-CI #2836-000011-24 and #00123740-CI #2836-000012-24 were related to infection prevention and control.

The following Complaint Intake(s) were inspected on:

- Intake #00127352 was related to skin and wound management and housekeeping, laundry and maintenance services.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1321-0003 related to FLTCA, 2021, s. 6 (7)
Order #002 from Inspection #2024-1321-0003 related to O. Reg. 246/22, s. 102 (2) (b)

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

Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Falls Prevention and Management

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: 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).

The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

The home has failed to ensure that there were posted signages at entrances and throughout the home in accordance with the "IPAC Standard for Long Term Care Homes September 2023" (IPAC Standard). Specifically, no signs were posted that listed the signs and symptoms of infectious diseases for self-monitoring as well as steps that must be taken if an infectious disease is suspected or confirmed in any individual as required by Additional Screening requirements 11.6 under the IPAC Standard.

Rationale and Summary

During the inspection it was observed the signs and symptoms of infectious diseases for self-monitoring signage was posted at the entrance but not throughout the home. The IPAC Lead verified this and then placed the signage in the elevators and at the nursing stations.

Sources: Observations and an interview with the IPAC Lead.

Date Remedy Implemented: October 11, 2024.

WRITTEN NOTIFICATION: Pest control

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 94 (2)
Pest control
s. 94 (2) The licensee shall ensure that immediate action is taken to deal with pests.

The licensee failed to ensure that immediate action was taken to deal with suspected pests in a resident space.

Rationale and Summary

On a specified date, the nurse on duty documented pests were found in the resident's room.

The Administrator stated they were not aware pests had been reported to the home on that specific date. The pests were reported in the room again at another date, and the home did take immediate action to treat the room.

The Director of Environmental Services (DES) stated they were not aware that pests had been reported in the resident's room on that specific date, and therefore immediate action was not taken to address the pests.

The home failed to take immediate action when pests were reported in the resident's room on the specified date, which delayed treatment and made the resident vulnerable to pests.

Sources: resident clinical records, interview with Administrator and Director of Environmental Services.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #003 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).

The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

In accordance with additional requirement 9.1 under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April 2022) requires that routine practices were to be followed in the IPAC program. Specifically, hand hygiene, including, but not limited to, before aseptic procedures, before initial resident/resident environment contact and after resident/resident environment contact was not completed.

Rationale and Summary

On a specified date a PSW was pushing a trolley of soiled linen. The PSW stopped at the nursing station before exiting the unit and removed their gloves and immediately picked a new pair of gloves out of a box without performing hand hygiene. The IPAC Lead confirmed the PSW should have performed hand hygiene after removing their gloves and putting their hands in a clean box of gloves.

On the same day, a RN was observed coming out of a resident's room without performing hand hygiene. The IPAC Lead confirmed the RN should have performed hand hygiene after resident environmental contact.

Staff failing to complete hand hygiene at the required moments posed a risk of increased infectious disease transmission.

Sources: Observation conducted on a specified date, and an interview with the IPAC Lead.