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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Public Report

Report Issue Date: February 21, 2025

Inspection Number: 2025-1321-0001

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 6-7, 10-14, 18-19, 21, 2025
The inspection occurred offsite on the following date(s): February 20, 2025

The following intake(s) were inspected:

- Intake: #00133459 - a complaint related to a resident's care, falls prevention and management and responsive behaviours
- Intake: #00137191 - a complaint related to air temperature and resident care
- Intake: #00137671/Critical Incident (CI) #2836-000002-25 - related to a disease outbreak

The following intake was completed:

- Intake: #00140077/CI #2836-000003-25 - related to a disease outbreak

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

Resident Care and Support Services

Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
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 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident was reassessed, and their plan of care was reviewed and revised when an intervention was no longer necessary. The resident's plan of care indicated that they required an intervention for their locomotion on the unit. Staff indicated that the resident no longer required this intervention.

Sources: Observation, a resident 's clinical records and interviews with staff.

WRITTEN NOTIFICATION: Air temperature

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)

Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The licensee has failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius. The home's air temperature logs indicated that the home's temperatures were below 22 degrees Celsius on several occasions in the mornings, evenings or nights in August and September 2024. There was no documentation on the actions taken to adjust the temperature to meet the minimum requirement.

Sources: Home's air temperature logs, home's Systems Temperature Control Policy (V-C-10.40) and interview with the Director of Environmental Services.

WRITTEN NOTIFICATION: Air temperature

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2)
Air temperature
s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home.
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.
3. Every designated cooling area, if there are any in the home.

The licensee has failed to ensure that temperatures were measured and documented in writing outside of the May 15 to September 15 period. The Director of Environmental Services stated that the home did not measure air temperatures in

the home for the time outside of the May 15 to September 15 period in 2024.

Sources: Interview with the Director of Environmental Services.

WRITTEN NOTIFICATION: Air temperature

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (3)
Air temperature
s. 24 (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The licensee has failed to ensure that the temperature required to be measured under subsection (2) was documented at least once every morning. The home's air temperature log indicated that there was no air temperature measurement documented in the morning on July 13, 2024 for all units in the home.

Sources: Home's air temperature logs and interview with the Director of Environmental Services.

WRITTEN NOTIFICATION: Responsive behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

The licensee has failed to ensure that there were written strategies, including techniques and interventions to manage a resident's responsive behaviour. The resident had responsive behaviour. Staff indicated that they had interventions to manage their behaviour. However, the strategy to manage this behaviour was not included in the resident's plan of care.

Sources: A resident's clinical records and interviews with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that strategies were implemented to respond to a resident's responsive behaviours. The resident's care plan indicated that they required a specific device to prevent other residents from wandering into their room. Upon observation, the device was not applied when the resident was in their room.

Sources: Observation, a resident's clinical records and interviews with staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #007 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 any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Additional Requirement 9.1 of the IPAC Standard for Long-Term Care Homes required Routine Practices be followed in the IPAC program. Specifically, s. 9.1 (b) around hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact). A Registered Nurse (RN) was observed to have not performed hand hygiene prior to and after medication administration, and contact with residents and their environment.

Sources: Observation on February 7, 2025 and interviews with staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
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 that on every shift, symptoms indicating the presence of infection in residents were recorded in accordance with any standard or protocol issued by the Director. Two residents were diagnosed with infections. There was missing documentation to support the monitoring of the residents' signs and symptoms of infection on multiple shifts.

Sources: Residents' clinical records and interview with the IPAC Lead.