Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 3, 2016	2016_270531_0018	001830-16/010598-16/012172-16/001032-15/013774-15/000486-16	Complaint

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Fieldstone Commons Care Community
1000 Ellesmere Road SCARBOROUGH ON M1P 5G2

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SUSAN DONNAN (531)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 9,10, 11, 12, 13, 16 and 17, 2016.

Log #001032-15 regarding accommodation services- maintenance
Log #001830-16 and log #010598-16 regarding accommodation services-housekeeping
Log #000486-16 regarding activation programs
Log #013774-15 regarding reporting and complaints
Log #012172-16 regarding care and services

During the course of the inspection, the inspector(s) spoke with residents, residents' families, personal support workers, registered practical nurses, registered nurses, a physiotherapy aide, activity aides, the activation program manager, a maintenance worker, housekeeping aides, the environmental services manager, the Director of Care and the Administrator.
During the course of the inspection the inspector, toured the home, observed resident care and services, reviewed residents health care records, reviewed environmental services reports; activation reports and appropriate policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Falls Prevention
Recreation and Social Activities
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 6 (7) in that the care set out in resident #014's plan of care was not provided as specified in the plan pertaining to falls prevention.

In reference to Log # 012172-16:

On a specified date a complainant was received by the Ministry of Health and Long Term Care from resident #014's substitute decision maker (SDM) that indicated on a particular date resident #014 fell and sustained an injury requiring transfer to hospital for further assessment. The SDM indicated that a fall intervention for resident #014 was not in place at the time of the fall.

Critical incident # 2906-000013-16 indicates the following:

On a specified date resident #014 fell and sustained an injury requiring transfer to hospital for further assessment;and the resident returned to the home the same day.

Resident #014's care plan for the particular date was reviewed and indicated the following :
- Resident #014 diagnoses include a cognitive impairment and a history of falls.

RPN #121 and PSW #134 were interviewed and both confirmed being on duty on the specified date and responded to the incident. PSW #134 indicated that he/she had left resident #014's room for a few minutes to request a coworkers assistance in transferring resident #014 and returned to find the resident on the floor. PSW #134 and RPN #121 confirm that a fall intervention was not in place as specified in the care plan.

Subsequently the Administrator was interviewed and confirmed that a fall intervention was not in place as specified by the care plan and that the incident was reviewed and actions taken. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided as specified in the plan., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (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. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 101 (1) (3) whereby Resident #014's SDM did not receive a written response indicating what had been done to resolve the complaint or that the licensee believed the complaint to be unfounded and the

reasons for this believe.

In reference to Log #013774-15:
Resident #014's SDM submitted a verbal complaint to the Assistant Director of Care (ADOC) on a specified date identifying multiple concerns related to provision of care; which the Assistant Director of Care was going to investigate and provide a response. The SDM confirms that a response has not been provided.

On May 17, 2016 during an interview with resident #014's SDM he/she told inspector #531 that on particular date he/she verbally reported to the Assistant Director of Care; identified concerns related to the provision of care for resident #014. The SDM indicated that the ADOC was to investigate; review camera footage and provide a response; which had not been received at the time of the inspection.
The ADOC was unavailable for an interview as she is no longer employed by the home.

Subsequently during an interview with the Administrator she confirm that the previous ADOC who investigated the complaint had not provided resident #014's SDM with a written response that indicated what had been done to resolve the complaint or if the complaint had been believed to be unfounded and the reasons for this believe. The Administrator confirmed that she met with resident #014's SDM recently to discuss the concern; outstanding response and the actions taken. [s. 101. (1) 3.]

2. The licensee has failed to ensure that a documented record was kept in the home pertaining to resident #014's SDM's concerns related to the provision of care.

In reference to log # 013774-15

Resident #014's SDM submitted a verbal complaint to the Assistant Director of Care on a specified date identifying multiple concerns related to provision of care; which the Assistant Director of Care was going to investigate and provide a response. The SDM confirms that a response has not been provided.

On May 17, 2016 during an interview with resident #014's SDM he/she told inspector #531 that on a particular date he/she verbally reported to the Assistant Director of Care identified concerns related to the provision of care for resident #014. The SDM indicated that the ADOC was going to investigate; review camera footage and provide a response; which had not been received at the time of the inspection.
The Assistant Director of Care could not be interviewed as she is no longer employed at

the home.

Review of policy #: V1-G-10:00 Complaints-Response Guidelines:
Verbal complaints:
Step :
iv. report any follow up on verbal complaints from any source and complete a complaints log
v. provide a written response to the complaint within 10 business days.

Subsequently during an interview with the Administrator and review of the complaint logs, she confirmed that the ADOC did not complete a complaint log for this complaint as per process . [s. 101. (2)]

Issued on this 20th day of June, 2016

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.