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 soins 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
Nov 25, 2016	2016_302600_0017	031892-16	Resident Quality Inspection

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

GORDANA KRSTEVSKA (600), SUSAN SEMEREDY (501)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 9, 10, 14, 15, 16, and 17, 2016.

During the course of the inspection, the inspector(s) conducted a tour of the home, observed meal service, medication administration system, staff and resident interactions and the provision of care, and reviewed health records, complaint and critical incident record logs, staff training records, meeting minutes for Family and Residents' Council and relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with the executive director (ED), director of care (DOC), registered nurses (RNs), registered practical nurses (RPNs), nursing students (NS), personal support workers (PSWs), resident relation coordinator (RRC), Family Council president, Residents' Council president, director of dietary services (DDS), registered dietitian (RD), resident assessment instrument-minimum data set (RAI-MDS) coordinator, physiotherapist (PT), residents and substitute decision maker (SDM).

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
O.Reg 79/10 s. 36.	CO #001	2016_405189_0005	600

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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident’s care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an assessment of the resident and the resident’s needs and preferences.

Interview with resident #007’s substitute decision maker (SDM) during stage one of the resident quality inspection (RQI) revealed the resident’s food preference was not being accommodated. According to the SDM, resident #007 has a preference and loves a specified food. Because the identified food is not always available through the home’s menu, the family often bring food in. Interview with resident #007 and nursing student #110 confirmed the resident loves the specified food and the family often bring food from home for him/her.

Record review revealed the registered dietitian (RD) assessed resident #007 for poor food and fluid intake on a specified date. Interview with the RD revealed he/she did not observe or interview the resident or his/her SDMs for food preferences. According to registered practical nurse (RPN) #113, he/she has never spoken to the RD regarding resident #007’s preference for an identified food. RPN #113 is aware resident #007 loves the identified food and even asks for it for breakfast.

Interview with the director of dietary services (DDS) revealed he/she was unaware resident #007 preferred the specified food on a regular basis. The DDS indicated that the identified food could be available to the resident as needed if requested.

Interview with the executive director (ED) confirmed that the home had failed to ensure

that resident #007’s plan of care was based on resident #007’s needs and preferences. [s. 6. (2)]

2. The licensee has failed to ensure the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

On an identified date during stage one of the RQI, resident #002 was observed to be in a tilted wheelchair. Interview with personal support worker (PSW) #117 stated it is a personal assistance services device (PASD) for safety as the resident can become agitated and move around. Interview with RPN #113 stated resident #002 is in a tilted wheelchair for comfort because he/she can be agitated sitting straight and will move around in the wheelchair.

Review of the MDS assessment report dated for a specified date indicated resident #002 was admitted to the home on specified date he/she had memory problems and severely impaired cognitive skills for daily decision making. The resident had a wheelchair as a primary mode of locomotion and he/she was wheeled by staff. Review of resident #002's written plan of care revealed the resident had a physical device to promote repositioning, comfort and safety. Review of the resident's assessment record failed to reveal if resident had been reassessed for using the PASD. Review of the progress notes failed to reveal that the resident's response to the use of PASD had been evaluated.

Interview with RPN #113 confirmed resident #002 had never been reassessed for the use of a PASD. The staff have just been monitoring him/her every hour and repositioning him/her every two hours when he/she is up in the wheelchair.

Interview with resident assessment instrument (RAI) coordinator #116 confirmed residents who used PASD are to be reassessed every quarter using the electronic assessment tool designed for PASD assessment.

Interview with director of care (DOC) confirmed resident #002 should have been reassessed at least every six months for using the PASD. [s. 6. (10) (b)]

3. Resident #003 triggered from stage one of the RQI for weight loss. Record review revealed resident #003 had a recent weight loss of an identified amount from June to September 2016, representing an eight per cent significant weight change. Resident #003 had further weight loss at the time of this inspection with a low body mass index.

Review of progress notes revealed resident #003 was receiving treatment for a specified medical condition. Review of the plan of care revealed the resident was receiving nutrition interventions at meals to maintain weight.

Observations at lunch on November 14 and 16, 2016, revealed when staff tried to assist resident #003 to drink his/her milkshake, the resident did not swallow and the milk poured from his/her mouth. Review of the resident's progress notes revealed RN #129 had documented on an identified date that he/she had to cue resident #003 with specific words so he/she will not spit it out. An interview with RN #129 revealed the above mentioned technique works well so that resident #003 will swallow without spitting out food and liquids. RN #129 also mentioned he/she thickens his/her beverages to make it easier for resident #003 to swallow without coughing.

Review of resident #003's written care plan revealed that RN#129 updated the eating section with the above noted technique on an identified date, after the inspector had spoken with him/her. Observation at lunch on day after revealed RN #109 and student RPN #124 both attempted to assist resident #003 with his/her milkshake but the liquid was not swallowed and poured out of his/her mouth. An interview with student RPN #124 revealed he/she was unaware of the specific technique in resident 003's plan of care but when he/she attempted the technique, resident #003 was able to consume all of the milkshake and other beverages. An interview with RN#109 revealed he/she was not aware of the above technique and admitted he/she knew resident #003 was exhibiting increased difficulty swallowing but had not made a recent referral to the RD or a speech language pathologist.

Review of a nutritional assessment made by the RD on an identified date, revealed that a referral had been received for resident #003 regarding coughing with thin fluids. In this assessment the RD was unable to observe resident #003 drinking fluids but was told by the regular nurse that resident's coughing on fluids was inconsistent. No new interventions were recommended. An interview with RD #130 confirmed he/she assessed resident #003 for swallowing in October and found no concerns.

An interview with the ED confirmed that the home had failed to ensure that resident #003 was reassessed and the plan of care reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

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 plan of care is based on an assessment of the resident and the resident's needs and preferences, and
to ensure the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

On November 10, 2016, at 0950 hours inspector #600 observed resident #008 had breakfast in his/her room and noted a cup with medications on his/her overbed table. The resident took the medication by him/herself after finishing his/her meal while the inspector was there.

Interview with the resident indicated the registered nurses often gave him/her medications to take on his/her own when he/she had meal in the room without supervision.

Review of resident #008's medication administration record revealed the resident had the identified medication at 0800 hours:

Review of the resident's chart and physician's order failed to reveal that an order had been provided for self-administration of medication for resident #008.

Interview with registered nurse (RN) #111 confirmed the resident did not have a physician's order for resident #008 to self-administer medication.

Interview with the DOC confirmed the registered staff are to supervise the resident until medication is taken. The registered staff are not to leave the medication in residents' rooms, but to stay with the resident until all medications are taken by the resident. [s. 131. (5)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure staff participate in the implementation of the infection prevention and control program.

Observation on November 15, 2016, revealed Personal Protective Equipment (PPE) was hanging on the door of an identified room. There was no signage to indicate what PPE was necessary for staff and visitors to wear and nothing to direct people to see the nurse in charge before entering.

An interview with RN #109 revealed the resident in the identified room was in isolation since the previous week because the resident's family member who had been visiting regularly had been diagnosed with an infection. RN #109 confirmed a sign to indicate contact precautions should have been placed on the door beside the PPE.

An interview with the DOC and Nurse Manager (NM) #132 confirmed the resident in the identified room was in isolation for a possible infection and staff and visitors were to practise contact precautions by wearing a gown and gloves until the incubation period of approximately four weeks had ended. The DOC and NM confirmed that a sign should have been placed on the door to provide direction for those entering the room and prevent possible contamination to others. [s. 229. (4)]

Issued on this 15th day of December, 2016

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

Original report signed by the inspector.