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 soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 12, 2017	2017_626501_0023	026519-17	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

SUSAN SEMEREDY (501), DEREGE GEDA (645)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 22, 23, 24, 27, 28, 29, 30, December 1, 4, and 5, 2017.

Intake # 014146-17 related to follow up of compliance orders was inspected concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Assistant Directors of Care (ADOCs), Nurse Managers (NMs), Registered Dietitian (RD), Director of Dietary Services, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Residents' Council President, Family Council President, residents, and Substitute Decision Makers (SDMs).

During the course of the inspection, the inspector(s) observed staff and resident interactions and the provision of care, reviewed health records, staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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)**

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
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #002	2017_626501_0011	501
O.Reg 79/10 s. 54.	CO #003	2017_626501_0011	645
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2017_626501_0011	501

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

During the initial tour of the home on November 22, 2017, Inspector #645 observed the following:

•The clean utility room on an identified floor was open. The door was accessible to the residents and no staff members were observed in the area. Inspector #645 observed two used unlabelled disposable razors and one unlabelled nail cutter stored in a yellow storage box that was open and accessible to residents.

•On another identified floor, a storage linen cart parked on the hallway had a storage box that contained used unlabelled disposable razors and a nail cutter that were stored and were accessible to residents. RPN #104 stated the box should always be locked and the disposable razors were supposed to be disposed of after use.

•A linen storage cart on another identified floor also had a blue storage box that was open and accessible to residents. Inspector #645 observed three used disposable razors stored in the box which were accessible to residents.

•On another identified floor, a blue storage box was observed unlocked and had three unlabelled unused disposable razors and one razor labelled under resident #050 stored in it. RPN #116 was notified and he/she reiterated that the sharp materials should be disposed of or stored safely. He/she then removed the sharp materials and disposed of them.

•On an identified floor, the resident tub room was observed wide open and no staff members were in the area. Inside the tub room wheelchairs, a weighing machine and mechanical sit to stand lifts were stored that are a potential fall hazard. Charge nurse #117, closed the tub room door and stated that the door should be locked all the time.

An interview with the DOC confirmed that all shower/tub room doors must be locked all the time and all disposable razors need to be disposed of immediately. [s. 5.]

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 home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee had failed to ensure that staff involved in the different aspects of care collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated, consistent with and complemented each other.

Resident #008 triggered from stage one of the inspection for weight loss. Record review revealed resident #008 had an identified amount of weight loss during an identified time period.

Review of progress notes revealed the Registered Dietitian (RD) responded to a referral from nursing on an identified date, regarding resident #008. In this note, the RD noted a weight loss over an identified period and assessed that resident #008 was not meeting his/her energy requirements. The RD added an identified snack at a specified nourishment time.

Observation the day after the above assessment, revealed resident #008 did not receive the identified snack at the specified nourishment time. An interview with PSW #100 and review of the dietary list on the snack cart revealed resident #008 was not scheduled to receive any snack at the specified nourishment time.

An interview with the Director of Dietary Services revealed the RD communicates with Dietary Services by sending a report of recommendations at the end of the day on a communication tool. Review of this tool for the date of the RD's assessment, revealed there was no recommendation for resident #008 to receive a snack at a specified nourishment time.

An interview with the DOC confirmed that the home failed to ensure that the RD and Dietary Services collaborated with each other in the implementation of the plan of care for resident #008 so that the different aspects of care were integrated, consistent with and complemented each other. [s. 6. (4) (b)]

Issued on this 13th day of December, 2017

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

Original report signed by the inspector.