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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 20, 2019	2019_780699_0012	008212-17, 009786-17, 010062-17, 011444-17, 011613-17, 014291-17, 015969-17, 018889-17, 024146-17, 025794-17, 029434-17, 002634-18, 006058-18, 006929-18, 009271-18, 010372-18, 018038-18, 025114-18, 025717-18, 027125-18, 001649-19, 005101-19	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM 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

PRAVEENA SITTAMPALAM (699), AMY GEAUVREAU (642), BABITHA SHANMUGANANDAPALA (673), JENNIFER LAURICELLA (542), MICHELLE BERARDI (679), STEPHANIE DONI (681)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 3-7, 10, 11 2019.

The following Critical Incident System (CIS) intakes were inspected during this inspection:
Log #025717-18 (CIS 2906-000036-18), 018889-17 (CIS 2906-000074-17), 025114-18 (CIS 2906-000034-18), 008212-17 (CIS 2906-000053-17), 015969-17 (CIS 2906-000068-17), 024146-17 (CIS 2906-000077-17), and 009786-17 (CIS 2906-000013-17) related to staff to resident abuse;
Log #018038-18 (CIS 2906-000029-18) related to resident to resident abuse;
Log #009271-18 (CIS 2906-000019-18), 011613-17 (CIS 2906-000062-17), 010372-18 (CIS 2906-000020-18), 002634-18 (CIS 2906-000007-18), 025794-17 (CIS 2906-000078-17), 006929-18 (CIS 2906-000012-18), 010062-17 (CIS 2906-000060-17), 005101-19 (CIS 2906-000009-19), 027125-18 (CIS 2906-000038-18), and 006058-18 (CIS 2906-000013-18) related to falls;
Log #029434-17 (CIS 2906-000083-17) related to unexpected death of a resident;
Log # 011444-17 (CIS 2906-000061-17) related to medication administration error; and
Log #001649-19 (CIS 2906-000003-19) and 014291-17 (CIS 2906-000065-17) related to fracture of unknown cause.

A Written Notification (WN) under LTCHA, 2007, c.8, s. 6 (10)(b), identified in this inspection (Log # 029434-17) will be issued under CIS inspection 2019_780699_0011 concurrently inspected during this inspection.

A Written Notification related to LTCHA, 2007, c.8, s. 19 (1), identified in concurrent inspection 2019_780699_0011 (Log #022806-17) will be issued in this report.

During the course of the inspection, the inspector(s) spoke with Executive Director, interim Director of Care (DOC), Assistant Directors of Care (ADOCs), Nurse

Managers (NMs), Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Physiotherapist (PT), Environmental Supervisor (ES), Personal Support Workers (PSW), rehabilitation assistant, residents and family members.

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

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
7 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	Légende 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse towards residents by anyone had occurred shall immediately report the suspicion and the information upon which it was based to the Director.

A CIS report was submitted to the Director for an alleged incident of staff to resident physical abuse.

During the course of the inspection the inspector reviewed the employee file for PSW #108. There were two other incidents of abuse toward a resident. Neither of these incidents was reported to the Director.

Inspector #542 interviewed the interim DOC who confirmed that they did not notify the Director regarding the neglect of a resident by PSW #108.

An interview with ADOC #118 was conducted with Inspector #542, in which, ADOC #118 indicated that the incident should have been reported to the Director however it was not reported. [s. 24. (1)]

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 a person who has reasonable grounds to suspect that abuse of a resident by anyone had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director, 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 has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

A CIS report was submitted to the Ministry of Health and Long-term Care (MOHLTC) related to resident #011’s transfer to hospital for an identified condition. In the hospital, resident #011 was diagnosed with identified conditions and later passed away in hospital.

A record review of resident #011’s electronic medication administration record (MAR) and the record of physician’s orders indicated that, resident #011 was treated for a specific diagnosis with an identified medication, as per Physician #138’s orders. A review of the results of resident #011’s report on a specific date, and diagnostic imaging records on a

specific date, indicated a specific diagnosis.

A record review of resident #011’s progress notes between specified dates indicated that resident #011 experienced a symptom, and displayed increased responsive behaviors during a specific time period. On a specified date, resident #011 was placed on isolation precaution for identified symptoms, and then sent to hospital.

Record review of resident #011’s progress notes, record of physician’s orders, written plan of care, electronic medication administration record, and electronic assessments between specific dates did not include any revisions to resident #011’s plan of care, or documentation as to why there were no revisions to their plan of care in relation to their symptoms or their above mentioned diagnostic assessments.

In an interview, RN #137 stated that, following the completion of an identified medication for residents diagnosed with specific condition, staff are to continue to assess and monitor them for symptoms and report these symptoms to the physician for further assessment to determine appropriate interventions.

In an interview, Physician #138 stated that the nursing staff are expected to collaborate with them in this way; however, resident #011’s symptoms between a specified time period, had not been brought to their attention.

In interviews, Physician #138 and ADOC #101 acknowledged that nursing staff had failed to collaborate with Physician #138 in regards to resident #011’s condition for a specified time period. [s. 6. (4) (a)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #032 and #013 were protected from abuse/neglect by anyone.

Ontario Regulation 79/10 defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that were performed by anyone other than a resident.

A CIS report was submitted to the Director related to an allegation of staff to resident abuse. The CIS report indicated that resident #032 reported that a specified number of staff members went into the resident's room and forcefully got them up from bed by an identified part of their body, despite the resident refusing. The CIS report also indicated that the resident was very upset and that they had altered skin integrity on an identified part of their body.

Inspector #681 reviewed the home's investigation notes related to the incident, which indicated that, during the home's investigation, PSW #134 stated that they observed PSW #126 continue to provide care to resident #032's even though the resident was saying “no, why are you doing this?”.

During an interview with PSW #126, they stated that the resident was saying “no, no, don't touch me”, as PSW #126 continued to provide the resident's with a specified care intervention.

The Inspector reviewed a document that indicated that PSW #126 received disciplinary action because, through the home's investigation, it was determined that PSW #126 proceeded with care despite the resident refusing and that the resident was distraught and did not leave their room all day.

During an interview with ADOC #101, they stated that through the home's investigation, the allegation of emotional abuse was substantiated. ADOC #101 stated that PSW #126 proceeded with providing specific care despite the resident refusing.

2.Ontario Regulation 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being

of one or more residents.

The MOHLTC received a complaint from FM #200 related to the lack of specific care provided to resident #013 on two separate incidents.

A review of an email sent by FM #200 to DOC #100, stated that they had spoken with RPN #153, and that the night staff did not know how to change a specific medical device; therefore, they waited until RPN #153 arrived for work, during which time resident #013 was left in a specific condition for a specified amount of time.

A review of resident #013's progress notes indicated documentation by RPN #152 stating that resident #013 had complained of a specific symptom at an identified time, their medical device was observed to be blocked, and that they had informed the morning staff, RPN #153, to attend to resident #013's medical device. Documentation by RPN #153 indicated that the medical device was attended to upon arrival to their morning shift.

A review of resident #013's eMAR indicated that a specific medication prescribed to be used when needed for resident #013 was not administered to them. Records did not indicate that a specific assessment was completed, nor any therapeutic measures were implemented.

In an interview, DOC #100 stated that RPN #152 should have either provided the PRN medication or requested assistance from someone else to attend to resident #013's medical device in this situation. DOC #100 further stated that fact finding was completed for this incident, and RPN #152 was provided education about specific symptom management as they were a new staff member at this time.

A review of an email sent by FM #200 to DOC #100, indicated a request for a meeting to discuss an incident from that same day where resident #013 experienced a severe symptom for a specific period of time. It further stated that RPN #155 did not address resident #013's complaints of a specific symptom despite the resident using the call bell three times to alert RPN #155 of the specific symptom, and FM #200 calling RPN #155 and the nurse manager twice via telephone to request them to manage the specific symptom.

A review of RPN #155's personnel file, including a letter indicated that resident #013 had called RPN #155 at specific times on a specific time, as the resident was experiencing a

specific symptom at which time RPN #155 did not asses the resident's specific symptom, provide reassurance or offer any therapeutic measures for a specified time period. It further stated that although RPN #155 had the opportunity, knowledge, skill and judgement to remove the resident's medical device when pain was reported, RPN #155 waited until a significant time later. Following the home's investigation of the incident, RPN #155 received disciplinary action for findings related to neglect.

In an interview, ADOC #101 acknowledged that during this incident, resident #013 had not been protected from neglect by RPN #155.

The severity of this finding was a level 3, indicating actual harm. The scope was a level 1, indicating the issue was related to one of three residents reviewed. A review of the home's compliance history was a level 3, indicating previous non-compliance to the same subsection in the last 36 months. According to the judgement matrix, a compliance order (CO) is warranted, however, it has been confirmed through the inspection and the home's compliance history since the time of these incidents, that non-compliance related to LTCHA 2007, c.8, s. 19 (1) has been addressed and rectified by the home. A written notification (WN) is being issued. [s. 19. (1)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A CIS report was submitted to the Director related to an incident of staff to resident abuse. Please refer to WN #3 for further details.

During an interview with PSW #134, they stated that they witnessed resident #032's caregiver continue to provide care to the resident even though the resident was refusing the care and saying "no". PSW #134 stated that residents have the right to refuse care and that, if resident #032 was on PSW #134's assignment, the resident would not have been provided with the care at that time.

Inspector #681 reviewed the home's policy titled "Prevention of Abuse & Neglect of a Resident" (VII-G-10.00), with a revision date of the January 2015. The policy indicated that if an employee witnessed an incident, or had any knowledge of an incident, that constituted resident abuse, the staff member was to stop the abusive situation, remove the resident from the abuser, and immediately inform the Executive Director, Administrator, or Charge Nurse in the home.

The Inspector reviewed a letter addressed to PSW #134. The letter indicated that PSW #134 witnessed a coworker continue to provide care even after the resident refused the care and asked the PSW to stop. The letter also indicated that PSW #134 acknowledged that the resident's right to refuse care was violated, but that the PSW did not intervene or report the incident.

During an interview with ADOC #101, they stated that PSW #134 was present when the incident occurred and that they were given a letter because PSW #134 did not intervene or report the concern as per the home's policy. [s. 20. (1)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the results of every investigation undertaken was reported to the Director.

1. A CIS report was submitted to the Director for an alleged incident of staff to resident physical abuse.

Inspector #542 reviewed the home's investigation results and the CIS report. The CIS report did not include the results of the home's investigation.

On June 5, 2019, Inspector #542 interviewed ADOC #118 who verified that the CIS report did not contain information regarding the results of the home's investigation.

2. A CIS report was submitted to the Director for an alleged incident of staff to resident physical and verbal abuse.

Inspector #542 reviewed the CIS report, which did not include the results of the home's investigation.

Inspector #542 interviewed ADOC #101 who indicated that the home did not submit the home's investigation results to the Director. [s. 23. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (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:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that written strategies, including techniques and interventions were developed to meet the needs of resident #021 with responsive behaviours.

A CIS report was submitted to the Director for an allegation of staff to resident abuse. The CIS report identified that resident #021’s family member felt that PSW #114 had abused resident #021, leaving a specified injury to the resident’s identified body part, as revenge for complaining to the home.

Inspector #679 reviewed the home’s internal investigation into the allegation of abuse and identified a transcript of an interview with PSW #114. The interview identified that resident #021 was exhibiting a responsive behaviour during care and that staff had held the resident's hands down.

In an interview with PSW #114, they identified that resident #021 had identified responsive behaviours. PSW #114 identified that around the time of the incident they were assisting resident #021 with personal care, and that they had held the residents hands as they were exhibiting a responsive behaviour. PSW #114 identified that they would reference a resident’s care plan to determine if they had responsive behaviours, and any interventions in place to manage the resident’s responsive behaviours. PSW #114 further identified that they were could not recall if resident #021 had interventions in place to manage their responsive behaviours.

Inspector #679 reviewed resident #021's care plan which was in place at the time of the incident, and did not identify any indication that the resident exhibited responsive behaviours, or any interventions to manage the responsive behaviours.

In an interview with Inspector #679, RPN #127 identified that resident #021 would exhibit identified responsive behaviours. RPN #127 identified that staff would reference a resident's care plan to determine if they had responsive behaviours, and any interventions in place to manage the resident's responsive behaviours.

In an interview with Inspector #679, the DOC identified staff would reference a resident's care plan, progress notes and life story to determine if they had responsive behaviours, and any interventions in place to manage the resident's responsive behaviours. The DOC identified that they had reviewed resident #021's electronic progress notes and care plan and did not identify any interventions to manage the resident's behaviours.

The severity of this finding was a level 2, indicating actual harm. The scope was a level 2, indicating the issue was related to two of three residents reviewed. A review of the home's compliance history was a level 3 , indicating previous non-compliance to the same subsection in the last 36 months. According to the judgement matrix, a compliance order (CO) is warranted, however, it has been confirmed through the inspection and the home's compliance history since the time of these incidents, that non-compliance related to O. Reg 79/10, r. 53 (1)(2) has been addressed and rectified by the home. A written notification (WN) is being issued. [s. 53. (1) 2.]

WN #7: 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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #053 was administered a specific

medication as specified by the prescriber.

The MOHLTC received a CIS related to a medication error that altered resident #053's health status. Review of the CIS report indicated that on a specific date, resident #053 was assessed to have a specific vital sign prior to being administered a specific medication. The nursing student accidentally crushed the medication and gave it to the resident in error. Resident was assessed by the physician that day and no symptoms were noted. The progress notes indicated that the resident was assessed one day later and noted that they had altered vital signs. Resident #053 was subsequently sent to hospital to be assessed.

Record review of the physician order indicated the following:
-A specific medication, one time daily, every two days for administration every other day with alternating identified dosage, hold if vital sign is lower than a specific range.

Record review of the progress notes indicated that resident was assessed to have a specific vital sign prior to the administration of medications. The student nurse in error crushed the medications and administered the medication. The resident was assessed and was asymptomatic at the time of assessment. The physician assessed the resident and ordered that resident be monitored every shift. Further review of the progress notes indicated that on a specified date, resident was assessed to have altered vital signs. The resident was sent to hospital and was sent back to the home. The physician discontinued the specific medication.

Record review of the emergency department report indicated resident #053 was seen for identified diagnosis, asymptomatic and was sent back to the home.

In an interview with ADOC #101, they stated that for resident #053, the physician prescribed order was not followed related to the administration of a specific medication.

The severity of this finding was a level 3, indicating actual harm. The scope was a level 1, indicating the issue was related to one of three residents reviewed. A review of the home's compliance history was a level 3 , indicating previous non-compliance to the same subsection in the last 36 months. According to the judgement matrix, a compliance order (CO) is warranted, however, it has been confirmed through the inspection and the home's compliance history since the time of these incidents, that non-compliance related to O. Reg 79/10, r. 131(2) has been addressed and rectified by the home. A written notification (WN) is being issued. [s. 131. (2)]

Issued on this 21st day of June, 2019

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

Original report signed by the inspector.