Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Feb 10, 2020	2020_751649_0001	019871-19, 020481-19, 022712-19	Complaint

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

JULIEANN HING (649)

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): January 8, 9, 10, 13, 14, 16, 17, 20, 30, 31, and off-site January 18 and 19, 2020.

**The following logs were inspected during this inspection.
Logs #019871-19/ Critical Incident System (CIS) #2906-000027-19 and #020481-19 related to prevention of abuse and neglect.
Log #022712-19 related to plan of care.**

During the course of the inspection, the inspector(s) spoke with the director of care (DOC), assistant directors of care (ADOCs), registered nurses (RNs), registered dietitian (RD), physiotherapist (PT), registered practical nurses (RPNs), personal support workers (PSWs), residents and family members.

Note: A Voluntary Plan of Correction (VPC) related to O. Reg. 79/10 s. 48 (1) and to LTCHA, 2007, c.8, s.6 (9), identified in this inspection and have been issued in critical incident system Inspection Report #2020_751649_0002, dated February 10, 2020, which was conducted concurrently with this inspection.

During the course of the inspection the inspector reviewed residents' health records, staffing schedules, investigation notes, conducted observations related to the home's care processes, and reviewed relevant policies and procedures.

**The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care**

During the course of this inspection, Non-Compliances were issued.

**2 WN(s)
2 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. 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 of resident #001 collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A complaint was reported to the Ministry of Long-Term Care (MLTC) expressing concerns related to the resident's altered skin integrity.

A review of resident #001's clinical record indicated they have an area of altered skin integrity. The resident was assessed by the wound care nurse who recommended treatment interventions for the area of altered skin integrity.

The resident was transferred to hospital and returned to the home on an identified date, upon which time the area of altered skin integrity had deteriorated. The wound care nurse assessed the resident at three and five week intervals post hospitalization, and on both occasions recommended a specified treatment type. The recommended treatment type was never implemented by the home.

During registered staff interviews they were unable to explain why the recommended specified treatment type had not been implemented for resident #001. Upon further inquiry with the home's management, the inspector was provided documentation of a late entry made by the resident's physician that the resident had a specified diagnosis based on a discussion the physician had with the resident's family members. This was the home's explanation as to why the recommended specified treatment type had never been initiated for resident #001. Prior to this late entry made by the physician there was no documentation in the resident's care plan of this specified diagnosis.

A review of care conference meeting notes the home had with the resident's family members did not indicate this specified diagnosis.

In separate interviews with RN #100 and RN #102, acknowledged that they were not aware of resident #001 having this specified diagnosis and was not aware of the physician entry until the inspector showed it to them.

In an interview with DOC #109, they acknowledged that there was no communication with the physician and the nursing staff of resident #001's specified diagnosis.

This non-compliance was issued as there was no collaboration between the physician and nursing staff after the resident was diagnosed with a specified diagnosis, since the registered staff were not aware of this diagnosis. [s. 6. (4) (a)]

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 staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident’s plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident’s condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #001 who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

A complaint was reported to the MLTC expressing concerns related to the resident's altered skin integrity.

A review of resident #001's skin and wound assessment completed on an identified date, indicated that the resident had signs of pain during treatment. A review of the resident's electronic-medication administration record (e-MAR) indicated no pain medication was administered to the resident when there was documentation on the above mentioned date that they had pain.

In an interview with RN #100, who completed the above assessment acknowledged that the resident had pain on the above mentioned date and they did not administered pain medication to the resident.

In an interview with DOC #109, they told the inspector that their expectation is if the nursing staff identify that a resident was in pain, they should follow the home's pain management process. [s. 50. (2) (b) (ii)]

2. The licensee has failed to ensure that resident #001 who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending upon the resident’s condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated.

A complaint was reported to the MLTC expressing concerns that resident #001 was not being turned and repositioned every two hours.

A review of resident #001's clinical record indicated that resident #001 had an area of altered skin integrity and was dependent on staff for turning and repositioning.

A review of video footage from the resident's room was provided to the inspector and reviewed. Dates and times were identified that resident #001 had not been turned and repositioned every two hours by staff as required.

In an interview with DOC #109, they explained that staff should be turning and repositioning the resident every two hours and would be very concern if staff were not doing this. [s. 50. (2) (d)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required and that any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated, to be implemented voluntarily.

Issued on this 3rd day of March, 2020

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

Original report signed by the inspector.