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

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Original Public Report

Report Issue Date August 16, 2022
Inspection Number 2022_1390_0001
Inspection Type
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

Long-Term Care Home and City
Fieldstone Commons Care Community
1000 Ellesmere Road Scarborough ON M1P 5G2

Lead Inspector
Noreen Frederick (704758)

Inspector Digital Signature
Noreen Frederick
Digitally signed by Noreen Frederick
Date: 2022.08.17 17:09:44 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 26, 28, 29, and August 2, 2022.

The following intake(s) were inspected:

- Log # 007110-22 (Complaint) related to Falls Prevention and Management

The following **Inspection Protocols** were used during this inspection:

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102 (2) (b)

The licensee has failed to ensure that staff offered or assisted the residents with hand hygiene prior to eating.

Specifically, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s. 10.4 (h) states that the licensee shall ensure that the hand hygiene program includes support for residents to perform hand hygiene prior to receiving meals and snacks.

Rationale and Summary

Lunch observations revealed that staff did not offer or assist residents with hand hygiene prior to the meal. Personal Support Worker (PSW) #100 stated that they missed residents hand hygiene. Infection Prevention and Control (IPAC) Lead #101 acknowledged that staff were expected to offer and assist residents with hand hygiene prior to eating.

Due to home not offering or assisting residents with hand hygiene prior to lunch, there was a risk for residents contracting an infection.

Sources: inspector's observations, interview with PSW #100 and IPAC lead #101.

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WRITTEN NOTIFICATION PLAN OF CARE

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6 (2)

The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of one resident.

Rationale and Summary

The resident's assessments revealed that they were at high risk of falls. However, their care plan indicated moderate risk of falls. Registered Practical Nurse (RPN) #111, and #112 stated that the care plan was not reviewed and revised according to the assessments.

Assistant Director of Care (ADOC) #113 acknowledge that the care plan needed to be reviewed and revised each time when an assessment was completed.

Due to the home failing to review and revise the resident's care plan, there was a potential risk of interventions not being implemented related to falls prevention and management.

Sources: resident's care plan, falls risk assessments, Interview with RPN #111, #112 and ADOC #113.

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WRITTEN NOTIFICATION COMMUNICATION AND RESPONSE SYSTEM

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 20 (a)

The licensee has failed to ensure that a call bell was easily seen, accessed and used by one resident at all times.

Rationale and Summary

The resident had a fall on an identified day. RPN #111 stated that the resident did not have access to the call bell at the time of their fall. ADOC #113 acknowledged that the resident needed to have their call bell accessible to them at all times.

The home's call bell response policy required staff to secure call bell cords in a safe and appropriate manner within reach by the resident at all times.

Due to the home failing to provide access to the call bell, there was a risk for the resident not receiving the assistance they required.

Sources: resident's progress notes, home's **c**all bell response" policy #VII-10.00 (last revised April 2019), interview with RPN #111, ADOC #113 and other staff.

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