Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002
torontodistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: January 10, 2023

Inspection Number: 2022-1390-0002

Inspection Type:
Complaint
Critical Incident System

Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP

Long Term Care Home and City: Fieldstone Commons Care Community, Scarborough

Lead Inspector	**Inspector Digital Signature**
Nital Sheth (500)	Nital Sheth Digitally signed by Nital Sheth Date: 2023.01.10 14:03:59 -05'00'

Additional Inspector(s)
Helina Leung (741076)
Kim Lee (741072)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 18, 21-23, 24 (off-site), 25, 28-30, December 1-2, 5, 2022.
The following intake(s) were inspected:

- Intakes #00001274, #00005195, #00005646, #00006151, #00006242, #00010928 related to fall resulting in into injury
- Intake #00002391, #00002574, #00002610, #00003313, #00005979 related to duty to protect
- Intake #00003304, #00004651, #00005176 related to injury with unknown cause
- Intake #00006537 related to transferring and positioning
- Complaint Intake #00013391 related to multiple concerns with duty to protect, skin and wound, continence care, use of assistive device, housekeeping and maintenance, responsive behaviour, and reporting complaints

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

Prevention of Abuse and Neglect
Resident Care and Support Services
Responsive Behaviours
Infection Prevention and Control
Skin and Wound Prevention and Management
Falls Prevention and Management
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Recreational and Social Activities
Reporting and Complaints
Continence Care

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting Requirement

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 24 (1)

The licensee has failed to ensure that a person who has reasonable grounds to suspect neglect of a resident by the staff that resulted in a risk of harm to the resident, immediately reported the suspicion and the information upon which it is based to the Director.

PSW #133 reported to the management, that they were informed by PSW #129 that PSW #115 did not provided care to residents during their shift.

The incident was first reported to the Director two days later, when the management became aware about the incident. PSW #129 acknowledged that they did not report the incident because the registered nursing staff worked on that day was not a regular staff.

The ADOC #128 verified that PSW #129 should have reported this incident immediately.

Sources: CIS, the home's investigation record, Interview with ADOC #128, DOC and other staff. [500]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care related to a specified device was provided to resident #023 as specified in the plan.

Rationale and Summary
The inspector observed resident #023 without a specified device on. PSW #126 did not apply the specified device to the resident and acknowledged that it should have been applied.

Sources: Resident #023's care plan, observation, progress notes, interviews with PSW #126. [741076]

WRITTEN NOTIFICATION: Manufacturer's Instructions

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26

The licensee has failed to ensure that staff performed rapid antigen test (RAT) in the home in accordance with manufacturers' instructions.

Rationale and Summary
The inspector observed Screener #136 and other screeners did not follow the manufacturer's instructions for the use of the rapid antigen test (RAT) on three occasions. The instructions on the RAT kit required the user let the swab stand in the extraction tube with solution for two minutes. Screener #136 and other screeners were observed to leave the swab in the extraction tube for under 15 seconds during three observations.

Screener #136 reviewed the manufacturer's instructions for the RAT and indicated they do not have time to wait two minutes with respect to the duration of time the swab should stand in the solution in the extraction tube.

The Team Member Surveillance Testing – Covid 19, IX-N-10.42 policy indicated the Nurse or designated individual (with appropriate training) will collect the swab and perform the test as per manufacturer's guidelines.

The IPAC Lead acknowledged that the staff should have followed the manufacturer's instructions while

performing RAT.

There was risk of harm to residents, staff and visitors related to not following the RAT device's instructions as they pertain to the accuracy of the test results and consequently potential spread of infectious disease.

Sources: IPAC observation, COVID-19 Rapid Response Rapid Test instructions, The Team Member Surveillance Testing -Covid 19 (Policy #IX-N-10.42, revised October 2022), interviews with screener #136, and the IPAC Lead. [741076]

WRITTEN NOTIFICATION: Skin and Wound

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 50 (2) (b) (ii)

The licensee has failed to ensure that a resident exhibiting an impaired skin integrity received an immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection.

Rationale and Summary:
PSW #122 reported to RPN #117 that resident #021 had an impaired skin integrity. RPN #117 did not conduct an immediate skin assessment but provided a Band-Aid to PSW #122 to apply on the resident. On the next shift, RPN #116 performed a skin assessment of the area and identified that resident #021 required an immediate treatment.

Nursing Manager #106 and Skin & Wound Lead #120 stated that RPN #117 would have been expected to perform a skin assessment immediately after it was reported to RPN #117 by PSW #122.

RPN #117 stated that they were new to the role at the time of the incident and did not know that a skin assessment needed to be completed immediately. As a result, the skin assessment and treatment were delayed. The resident required an immediate treatment to promote healing and prevent infection. Treatment was delayed however it did not impact the resident’s recovery.

Sources: Interview with RPN #117, interview with RPN #116, interview with Nursing Manager #106, interview with Skin & Wound Lead #120, resident #021’s medical record. [741072]

WRITTEN NOTIFICATION: Dealing with Complainants

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (e)

The licensee has failed to ensure that a documented record kept for a complaint included every date on which any response was provided to the complainant and a description of the response.

Rationale and Summary
A complainant raised a concern related to the home following a complaint procedure. The complainant requested to view video footage due to their concern about an identified incident between residents #023 and #025.

The complainant watched the video footage, in the presence of Nurse Manager #106 and the Resident and Family Experience Coordinator. The complainant became upset while watching the video, related to the incident.

The ED advised to the complainant that the team did not see any concern while watching the video footage and was unable to provide any documentation of this conversation with the complainant, including the date and description of their response.

Sources: Video recording, interviews (the complainant, ED, Nursing Manager #106, Resident and Family Experience Coordinator, RPN #137, IPAC Lead #128), records review (Progress Notes, Complaint Form, CIS. [741076]

WRITTEN NOTIFICATION: Duty to Protect

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 19 (1)

The licensee has failed to protect resident #001 from abuse by resident #002.

There was an altercation between resident #001 and #002. Resident #002 became upset with resident #001 and caused them injury.

Nurse Manager (NM) #106 verified the above mentioned incident as abuse from resident #002 to

resident #001, as it resulted with an injury.

Failure to prevent the altercation between residents, caused physical injury to resident #001.

Sources: Critical Incident System report, residents' progress notes, and interview with NM #106. [500]

COMPLIANCE ORDER CO #001 Transferring & Positioning

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 79/10, s. 36

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]: The licensee shall do the following:

1. Conduct an environmental scan of rooms on the identified unit, to ensure residents using transferring device have sufficient space for safe operation of the device.
2. Complete weekly audits for the identified staff members for three months.
3. Keep and maintain a written record of completion of the above.

Grounds
The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #020.

Resident #020 was transferred by PSW #110 and #111, using a mechanical device. During this transfer, resident #020 sustained injury.

PSW #111 verified that they did not use safe transferring and positioning techniques which resulted in injury to the resident.

ADOC #105 indicated that PSW #110, and #111 received discipline as a result of the home's investigation for the resident's unsafe transferring.

Failure of staff members following safe transferring techniques posed resident #020 at risk and caused them injury.

Sources: CIS, policy (VII-G-20.30, Safe Resident Handling), and interview with PSW #111, ADOC #105 and other staff. [500]

This order must be complied with by March 17, 2023

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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002
torontodistrict.mltc@ontario.ca

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.