Ontario

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

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: March 6, 2023	
Inspection Number: 2023-1390-0003	
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 Joy Ieraci (665)	**Inspector Digital Signature** Maria Joy Ieraci Digitally signed by Maria Joy Ieraci Date: 2023.03.15 12:29:48 -04'00'
Additional Inspector(s) Cindy Ma (000711) was present during the inspection.	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 13, 14, 16, 17, 22,23 24, 27, and 28 (Off-Site), 2023.

The following intake(s) were inspected:

- Log #00016646 (CIS #2906-000049-22), related to a fall and;
- Logs #00017497 (Complaint), #00018668 (Complaint), and #00017621 (CIS #2906-000004-23), related to pain management, nutrition and hydration, skin and wound, restraints and safe and secure home.

The following intake was completed in this inspection:

- Log #00015174 (CIS #2906-000044-22), related to a fall.

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

Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home

Residents' Rights and Choices
Pain Management
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 3 (1) 19. iv.

The licensee has failed to ensure that residents' personal health information within the meaning of the Personal Health Information Protection Act, 2004, was kept confidential in accordance with that Act.

Rationale and Summary

The computer screen on the medication cart was left unattended in the hallway in one resident home area (RHA). The names and personal health information (PHI) of residents were visible. There were no visitors in the vicinity at the time of the observation.

A Registered Practical Nurse (RPN) acknowledged that the computer screen should have been locked to ensure confidentiality of residents' PHI. The RPN locked the computer screen.

Failure to lock the computer screen when unattended could allow unauthorized access to residents' PHI.

Sources: Observation in one RHA; and interview with an RPN.

Date Remedy Implemented: February 17, 2022 [665]

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 set out in the plan of care was provided to a resident as specified in the plan.

A) Rationale and Summary

The resident was at nutritional risk and had a physician order for a supplement to be provided during the nourishment pass. The snack list on the nourishment cart indicated the resident was to receive the supplement and two other food items.

One of the food items was observed in the resident's room during a nourishment pass. A Personal Support Worker (PSW) confirmed that the supplement and the other food item were not available on the nourishment cart and the resident was provided the other food item.

There was a risk to the resident's nutrition and hydration status when the supplement and the food item were not provided to the resident.

Sources: Snack observation; review of the resident's clinical records; and interviews with the PSW and other staff. [665]

B) Rationale and Summary

A resident had a physician order for an intervention while in their mobility device. The resident was at risk for falls and the intervention was for their safety while in their mobility device.

About a month prior to the inspection, an RPN did not implement the intervention after providing care to the resident with a PSW. The RPN implemented the intervention 15 minutes later, when they were notified by a family member.

There was a risk of injury to the resident if they had fallen out of their mobility device when the intervention was not implemented.

Sources: Review of the resident's clinical records; and interview with the RPN. [665]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021 s. 6 (4) b

The licensee has failed to ensure that staff and others involved in the different aspects of care of a resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and are consistent with and complemented each other related to a nutritional supplement.

Rationale and Summary

A resident was at nutritional risk and the Registered Dietitian (RD) recommended a change to the timing of their supplement to optimize the resident's nutritional intake. The RD discontinued the supplement at snack time and changed it during a meal service.

The physician orders did not have an order to reflect the RD's recommendation. The physician re-ordered the supplement two weeks later, which did not reflect the RD's recommendation. The medication administration records (MARs) for two consecutive months in 2023, showed that the registered nursing staff documented that it was provided at snack time.

An RPN confirmed that the physician orders and the MARs indicated that the supplement was to be provided at snack time and there were no orders for the supplement during a meal service. The RPN indicated the dietary department had been providing the supplement during a meal service and was not consistent with the MARs and physician orders.

The RD acknowledged that they had missed writing an order regarding their recommendation of the supplement, which resulted in the inconsistency in the resident's plan of care.

There was a risk to the resident's nutrition and hydration status when the change in the supplement was not consistent in their plan of care.

Sources: Review of the resident's clinical records; and interviews with the RPN, RD and other staff. [665]

WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021 s.184 (3)

The licensee has failed to ensure that a policy directive that applied to the long-term care home (LTCH), the Minister's Directive: COVID-19 Response Measures for Long-Term Care Homes was complied with.

In accordance with the Minister's Directive, the licensee was required to ensure they managed the care of symptomatic and asymptomatic residents in shared rooms, as set out in the Ministry of Health COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units was followed.

Rationale and Summary

In accordance with the Ministry of Health COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units, when a symptomatic resident was in a shared room, the asymptomatic resident was to be placed on additional precautions and that partitions/barriers were present for separation between the beds.

One resident was placed on droplet/contact precautions due to respiratory symptoms. The roommate was placed on additional precautions after an observation three days later.

The shared room had signage indicating droplet/contact precautions. Two residents were in the room with the privacy curtains open between the two beds. One resident had a visitor who was wearing a surgical mask. The visitor brought the resident out of the room into the dining room for meal service.

At the time of the observation, a PSW confirmed that the roommate was not on additional precautions.

The IPAC Lead acknowledged that the roommate should have been placed on droplet/contact precautions at the same time as the other resident with respiratory symptoms. The IPAC Lead and PSW both indicated that the privacy curtains should have been closed between the two beds for infection prevention and control.

There was a risk of infection transmission to the roommate when the privacy curtains did not separate the two beds, and a risk of infection transmission to other residents and staff when the roommate was not placed on additional precautions.

Sources: Resident observations; review of clinical records for two residents, Minister's Directive: COVID-19 Response Measures for Long-Term Care Homes, August 30, 2022, and Ministry of Health COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units, Version 9, January 18, 2023; and interviews with the PSW and IPAC Lead. [665]

COMPLIANCE ORDER CO #001 INFECTION PREVENTION AND CONTROL

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

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

The licensee shall:

1. Re-train PSW #109 on the home's hand hygiene program, including the four moments of hand hygiene.
2. Re-train PSWs #104 and #113 on donning and doffing of Personal Protective Equipment (PPE).
3. Maintain a record of the training conducted, including the date, who provided the training and content of the training.
4. Conduct hand hygiene and the donning and doffing of PPE audits on PSWs #109, #104 and #113 weekly for 4 weeks, upon service of this report.
5. Maintain a record of the audits conducted, including who was audited, auditor and any actions taken to address concerns.

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

The licensee has failed to ensure the implementation of a standard issued by the Director with respect to IPAC.

A) The home has failed to ensure that Routine Practices were in accordance with the "IPAC Standard for Long-Term Care Homes April 2022". Specifically, the four moments of hand hygiene as required by Additional Requirement 9.1 (b) under the IPAC standard.

Rationale and Summary

A PSW repositioned a resident and proceeded to touch food items in the nourishment cart without performing hand hygiene.

The home's hand hygiene policy directed staff to follow the four moments of hand hygiene which included hand hygiene after resident contact. The staff were also directed to perform hand hygiene prior to handling food items.

The PSW acknowledged they did not perform hand hygiene as per the home's hand hygiene practices.

There was a risk of infection transmission to other residents and staff when the PSW did not perform hand hygiene after resident care and handled food items.

Sources: Resident Care Observation; review of home's policy titled Hand Hygiene, #IX-G-10.10, Last Approved April 2022, IPAC Standard for Long-Term Care Homes April 2022; and interviews with the PSW and other staff. [665]

B) The home has failed to ensure that Additional Precautions were in accordance with the "IPAC Standard for Long-Term Care Homes April 2022". Specifically, PPE requirements including appropriate application as required by Additional Requirement 9.1 (f) under the IPAC standard.

Rationale and Summary

On February 16, 2023, one RHA was in a Suspect COVID-19 Outbreak. A resident was a confirmed case and had signage for additional precautions and steps on donning PPE posted at their door.

The steps for donning PPE were Step One: Perform Hand hygiene; Step Two: Put on Gown; Step Three: Put on Mask/N95 Respirator; Step Four: Put on Protective eyewear and Step Five: put on Gloves.

A PSW was observed donning PPE in the incorrect order prior to entering the resident's room. They had put on their gloves after performing hand hygiene (Step One).

The PSW and IPAC Lead acknowledged that PPE was not donned in the correct order.

The effectiveness of the home's IPAC program may not be as effective when PPE was not donned in the correct order.

Sources: Provision of care observation; review of the resident's clinical records, Public Health Ontario's Signage: Putting On Personal Protective Equipment, IPAC Standard for LTCHs, April 2022; and interviews with the PSW, IPAC Lead and other staff. [665]

C) Rationale and Summary

The home was in a Confirmed COVID-19 Outbreak on February 19, 2023, in one RHA.

A PSW provided care to a resident, a confirmed case, with their isolation gown not tied at the waist.

The home followed Public Health Ontario's recommendation on putting on PPE, which indicated that the ties of isolation gowns were to be tied securely at the neck and waist.

The IPAC Lead indicated that the PSW did not wear the gown appropriately and there was a risk of infection transmission to the PSW and to other residents and staff.

There was a risk of infection transmission to the PSW and to other residents and staff when the isolation gown was not appropriately worn.

Sources: Provision of care observation; review of the resident's clinical records, Public Health Ontario: Putting on PPE and IPAC Standard for LTCHs, April 2022; and interviews with the PSW and IPAC Lead. [665]

This order must be complied with by April 18, 2023

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.