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: October 19, 2023

Inspection Number: 2023-1390-0007

Inspection Type:
Complaint
Critical Incident

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

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

Lead Inspector	**Inspector Digital Signature**
Kirthiga Ravindran (000760)	Kirthiga Ravindran Digitally signed by Kirthiga Ravindran Date: 2023.10.20 14:32:47 -04'00'

Additional Inspector(s)
Susan Semeredy (501)
Rajwinder Sehgal (741673)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 5-6, 10, 12-13, 16, 2023

The following intake was completed in this complaint inspection:

- Intake #00097423 related to admissions, absences and discharges

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake #00091131/CI#2906-000022-23 related to falls prevention and management
- Intake #00093685/CI#2906-000027-23 related to resident care and support services
- Intake #00095172/CI#2906-000028-23 related to pain management
- Intake #00096874/CI#2906-000030-23 related to prevention of abuse and neglect

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

Resident Care and Support Services
Infection Prevention and Control

Prevention of Abuse and Neglect
Responsive Behaviours
Pain Management
Falls Prevention and Management
Admission, Absences and Discharge
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

The licensee has failed to ensure that a resident's written plan of care included the use of a personal assistive service device (PASD).

Rationale and Summary
A resident was observed with a PASD applied, which was positioned so that the resident appeared restless and uncomfortable. When a staff member repositioned the resident, the resident was appreciative.

The resident's written plan of care did not include the use of the PASD until it was brought to home's attention by the inspector. A Registered Practical Nurse (RPN) indicated consent to use the PASD was obtained, but confirmed it was not in the written plan of care.

The home's policy indicated that once a resident was assessed to need a PASD, the written plan of care with the interventions and monitoring of the PASD should be updated.

Failing to include the use of a PASD in a resident's written plan of care put the resident at risk for harm related to adequate supervision and monitoring.

Sources: Observations, a resident's written plan of care, home's policy # VII-E-10.10 Personal Assistance Service Devices (PASDs) last Revised March 2019, and interviews with RPN and other staff. [501]

COMPLIANCE ORDER CO #001 Prevention of Abuse and Neglect

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

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

Retrain all direct care staff on an identified resident home area on the difference between consensual and non-consensual sexual activity between residents. This education must include the definition of sexual abuse as found in O. Reg. 246/22. The content of the education and records of the training shall be kept and given to the inspector upon request.

Grounds
The licensee has failed to ensure resident #005 was protected from abuse by a resident #004.

Rationale and Summary
Section 2 of the Ontario Regulation 246/22 defines sexual abuse as “any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.”

Video surveillance indicated that resident #004 entered resident #005's room. A PSW entered shortly after and found resident #004 trying to engage resident #005 in non-consensual activity.

There was impact to resident #005's emotional well-being as the resident was found in distress. Since the incident was not reported and action taken to prevent reoccurrence until several days after, resident #005 was at further risk of harm.

Sources: Home’s investigation notes, progress notes from resident #004's and #005's clinical record and interviews with PSW and other staff. [501]

This order must be complied with by November 29, 2023

COMPLIANCE ORDER CO #002 Prevention of Abuse and Neglect

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

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

Retrain all managers, including night nurse managers or night registered staff in charge, on identifying when and how to report incidents to the Director. Keep a documented record of this training to provide to the inspector upon request.

Grounds
The licensee has failed to ensure that an RPN and a Nurse Manager (NM) immediately reported the suspicion of abuse by a resident to co-resident to the Director.

Rationale and Summary
A PSW witnessed resident #004 trying to engage resident #005 in non-consensual activity. The PSW reported the incident immediately to an RPN and later to a NM. The RPN assessed resident #005 and documented the incident in their progress notes but not in the resident #004's progress notes. The incident only came to management's attention when the Associate Director of Care (ADOC) was reviewing resident 005's progress notes which is when it was reported to the Director and the police, more than three weeks later.

The NM stated they thought the incident was alleged abuse but was not aware of mandatory reporting requirements and indicated they thought the RPN had reported the incident to a manager on the day shift. The DOC admitted that managers also failed to identify the incident in their 24-hour report review.

Failing to report this incident of abuse put co-residents at risk of harm from the resident #004 as authorities and managers could not respond to prevent reoccurrence.

Sources: Home's investigation notes, progress notes from resident #004's and #005's clinical record and interviews with NM and other staff. [501]

This order must be complied with by November 29, 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.