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: January 3, 2024

Inspection Number: 2023-1390-0008

Inspection Type:
Complaint
Critical Incident
Follow up

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**
Henry Chong (740836)	Henry A Chong Digitally signed by Henry A Chong Date: 2024.01.03 15:14:03 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 14, 18-22, 2023

The following intake(s) were inspected:

- Intake: #00099845 - Follow-up related to resident to resident sexual abuse
- Intake: #00099846 - Follow-up related to resident to resident sexual abuse
- Intake: #00101860 - [Critical Incident (CI): 2906-000035-23] - Infection prevention and control
- Intake: #00102605 - [CI: 2906-000036-23] - Fall with injury
- Intake: #00102894 - Complaint related to fall with injury, and infection prevention and control

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The following intake(s) were completed in this inspection: Intake: #00099436 - [CI: 2906-000033-23], Intake: #00101616 - [CI: 2906-000034-23], and Intake #00103195 - [CI: 2906-000037-23] were related to fall with injury.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1390-0007 related to FLTCA, 2021, s. 24 (1) inspected by Henry Chong (740836)

Order #002 from Inspection #2023-1390-0007 related to FLTCA, 2021, s. 28 (1) 2. inspected by Henry Chong (740836)

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting critical incidents

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (2)
Reports re critical incidents

s. 115 (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 246/22, s. 115 (2).

The licensee has failed to report a critical incident after normal business hours using the Ministry's method for after hours emergency contact.

Rationale and Summary
On an identified date, a critical incident report was submitted by the home after normal business hours. The home did not use the Ministry's method for after hours emergency contact.

The Ministry of Long-Term Care (MLTC) Reporting Requirements - reference sheet sent on August 18, 2023 indicated that for critical incidents reported immediately outside of business hours, to call the Service Ontario After-Hours Line.

Infection Prevention and Control (IPAC) Lead #102 confirmed that the home submitted a critical incident report immediately but did not call the Ministry of Long-Term Care Home's after hours phone number.

Sources: Critical Incident Report 2906-000035-23; MLTC Reporting Requirements - reference sheet; and interview with IPAC Lead #102.

[740836]