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 27, 2024	
Inspection Number: 2024-1390-0002	
Inspection Type: 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 Lisa Salonen Mackay (000761)	**Inspector Digital Signature** Lisa A Salonen Mackay Digitally signed by Lisa A Salonen Mackay Date: 2024.04.02 14:06:23 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 14, 15, 18, 19, 2024.

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

- Intake: #00106741/CI#2906-000002-24; Intake: #00109403/CI#2906-000011-24 and Intake: #00110278/CI#2906-000014-24 were related to falls prevention and management.

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

Infection Prevention and Control
Falls Prevention and 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)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure resident's plan of care was reviewed and revised when the resident's care needs changed.

Rationale and Summary:
According to resident's care plan, a specific device should have been in place as a fall prevention intervention.

During an observation in resident's room, no specific device was in use. During interviews with a Personal Support Worker (PSW) and a Registered Practical Nurse (RPN) both confirmed the specific device was no longer in use. During interviews with the Physiotherapy (PT) and Falls Lead both acknowledged the specific device

had been in use for bed mobility, but had since been discontinued.

The care plan was updated on March 18, 2024.

There was minimal risk to the resident as the specific device was no longer used but had not been removed from the resident's plan of care.

Sources: Resident's clinical record and room observation, interviews with PSW, RPN, PT and Falls Lead.
[000761]

Date Remedy Implemented: March 18, 2024.