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 3, 2024
Inspection Number: 2024-1390-0004
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 23-25, 2024

The following intake(s) were inspected:

- Intake: #00122764/CI #2906-000026-24 - related to fall of resident resulting in injury
- Intake: #00126459/CI #2906-000032-24 - related to injury of unknown cause

The following intakes were completed in this inspection:

- Intake: #00121785/CI #2906-000024-24, Intake: #00123053/CI #2906-000028-24, Intake: #00125037/CI #2906-000029-24, and Intake: #00125917/CI #2906-000030-24 - related to fall of resident resulting in injury

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and 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 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the resident's plan of care regarding staffing assistance for bathing was provided to the resident as specified in the plan.

Rationale and Summary
The resident's written plan of care indicated they required a specific level of assistance for bathing. On three separate dates, it was documented that the resident did not receive the required level of assistance for bathing. The Personal Support Worker (PSW) verified that the resident did not receive the level of bathing assistance specified in their plan of care on those dates.

There was a risk of injury to the resident when staff did not provide the required assistance related to bathing as specified in their plan of care.

Sources: Resident's care plan and documentation task survey; interview with staff.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that staff documented the provision of the care set out in the plan of care for the resident's pain monitoring after diagnosis of an injury.

Rationale and Summary
The physician ordered for a pain assessment to be completed every shift after the resident was diagnosed with an injury.

A review of the resident's clinical records indicated that there was no pain assessment documented during one shift. The Registered Practical Nurse (RPN) confirmed that a pain assessment should have been documented in the resident's clinical records on that shift.

The home's failure to ensure that pain assessments are documented as ordered increased the risk of unmonitored pain and delayed pain management interventions.

Sources: Review of resident's orders, progress notes and other relevant clinical records; interview with RPN.

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that a resident was reassessed when they were demonstrating responsive behaviours.

Rationale and Summary:
A responsive behaviour assessment and referral was initiated for the resident's physical responsive behaviours during care. A Behavioural Support Ontario (BSO) assessment was completed for resident on a specified date, which stated to continue to monitor resident on current plan of care and then reassess in two weeks.

The resident's progress notes indicated that the resident demonstrated physical responsive behaviours on multiple occasions after the initial assessment. The BSO Lead confirmed that the resident should have been reassessed after the two weeks.

Failure to reassess and respond to resident's responsive behaviours increased risk of injury and increased pain.

Sources: Resident's assessments, progress notes, and other clinical records; interviews with BSO Lead and nursing staff.

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