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
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Original Public Report

Report Issue Date: August 8, 2024

Inspection Number: 2024-1390-0003

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): July 30-31, and August 1-2, 2024.

The following intake(s) were inspected in the Critical Incident System (CIS) Inspection:
• Intake: #00121290 - 2906-000022-24 - Related to a fall of a resident resulting in injury
• Intake: #00116035 - 2906-000018-24 - Related to Infection Prevention and Control (IPAC)

The following intake(s) were completed in the CIS Inspection:
• Intake: #00112710 - 2906-000015-24, Intake #00115655 - 2906-000017-24, and Intake #00120764 - 2906-000021-24 - Related to a fall of a resident resulting in injury

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

Infection Prevention and Control

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection for multiple residents were recorded.

Rational and Summary
An outbreak was declared on a resident home area. Multiple residents had symptoms and were placed on additional precautions. There was no recorded documentation of symptoms during multiple shifts for multiple residents.

The Infection Prevention and Control (IPAC) Lead indicated that registered staff were to document signs and symptoms of infection on the progress notes on Point Click Care (PCC) at least once per shift. The IPAC Lead verified that there was no documentation on PCC of symptoms for multiple residents on the indicated dates.

Failure of the home to record residents' symptoms indicating the presence of infection on every shift may lead to the home's inability to monitor the health status of residents and intervene appropriately.

Sources: critical incident report, interview with the IPAC Lead, clinical records of residents.