Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Sep 10, 2019	2019_780699_0011 (A2)	009963-17, 012192-17, 022806-17, 002983-19, 004908-19, 005285-19, 009086-19	Complaint

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Fieldstone Commons Care Community
1000 Ellesmere Road SCARBOROUGH ON M1P 5G2

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

Amended by PRAVEENA SITTAMPALAM (699) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Correction to Written Notification #1, s. 6. (10)(b), page 10. Resident number was changed from #52 to #54

Issued on this 10th day of September, 2019 (A2)

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

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Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

Amended by PRAVEENA SITTAMPALAM (699) - (A2)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 3-7, 10-14, 2019.

The following complaint intakes were inspected during this inspection:

Log #012192-17 related to toileting, transferring of resident, and neglect;

Log #005285-19 related to improper care, feeding concerns, improper hygiene, feeding and bruises of unknown cause;

Log #009086-19 related to denial of admission to the home;

Log #022806-17 related to pain management, and continence care;

Log #002983-19 related to heat concerns; and

Log #009963-17 related to transferring of resident, skin and wound concerns, care conferences and equipment concerns.

The following Critical Incident System (CIS) intakes were inspected during this inspection:

Log #004908-19, CIS report #CI 2906-000008-19- related to neglect.

A Written Notification (WN) under LTCHA, 2007, c.8, s. 19 (1), identified in this inspection (Log #022806-17) will be issued under CIS inspection 2019_780699_0012 concurrently inspected during this inspection.

A Written Notification related to LTCHA, 2007, c.8, s. 6 (10)(b), identified in concurrent inspection 2019_780699_0012 (Log #022806-17) will be issued in this report.

Off-site interviews were conducted from June 12-14, 2019.

During the course of the inspection, the inspector(s) spoke with Executive Director, interim Director of Care (DOC), Assistant Directors of Care (ADOCs), Nurse Managers (NMs), Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Physiotherapist (PT), Environmental Supervisor (ES), Personal Support Workers (PSW), rehabilitation assistant, residents and family members.

During the course of the inspection, the inspector(s) conducted observation of staff and resident interactions and the provision of care, reviewed resident health records, staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.

- **10 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.) Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. 2007, c. 8, s. 6 (7).

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. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that for resident #052, their plan of care provided clear direction on which lift to use for transfers.

The MOHLTC received a complaint related to multiple care areas. Further review of the complaint indicated concerns related to resident #052 being left unattended when transferred on to the toilet.

Review of resident #052's progress note indicated that resident #052 was assessed to be appropriate for use of an specific device for transfers. The progress notes further indicated that staff should supervise the resident during the toileting process due to resident #052's cognitive impairment.

Record review of resident #052's current care plan indicated the following for transferring:
-toileting: resident uses a device for toileting; and
-transfer: resident is unable to transfer themselves, assistance equipment required is device.

Further review of the care plan did not indicate what specific device must be used for transfers and toileting.

An observation of resident #052 being transferred for toileting was conducted by Inspector #699. The inspector observed resident #052 being transferred with a specific device with two staff present.

In an interview with PSW #146, they stated they would look at the care plan to find out how to transfer a resident. They acknowledged that for resident #052, the care plan was not clear on which device the resident should be using.

In an interview with RN #103, they stated that the care plan for resident #052 was not clear as it did not indicate which device should be used.

In an interview with ADOC #101, they acknowledged that resident #052's plan of care did not provide clear direction on which device to use for transfers. [s. 6. (1) (c)]

2. The licensee has failed to ensure that resident #052's care plan was followed related to leaving resident unattended on the toilet.

The MOHLTC received a complaint related to multiple care areas. Further review of the complaint indicated concerns related to resident #052 being left unattended when transferred on to the toilet.

Review of resident #052's progress note indicated that resident #052 was assessed to be appropriate for use of a specific device for transfers. The progress note further indicated that staff should supervise the resident during the toileting process due to resident #052's cognitive impairment.

An observation of resident #052 being transferred onto the toilet was conducted by Inspector #699. The inspector observed resident #052 being transferred with a specific device with two staff present. During the transfer resident #052 did not

hold on to the identified part of device and was not prompted to hold on to the identified part of device by the staff. Resident #052 was transferred onto toilet, the device was braked, PSW #146 stepped outside the room, and student RPN #140 remained with the resident. PSW #146 returned with PSW #147 and student RPN left the room. PSW #147 tried to encourage resident #052 to hold on to the identified part of the device, however the resident was unable to follow their direction. PSW #147 refused to assist with the transfer as the resident was unable to hold on to the identified part of device and left the room. PSW #146 left the room to call for assistance and resident #052 was left in the room unattended. PSW #146 returned with student RPN #140 to complete transfer back to wheelchair. After a few minutes of prompting, resident #052 was able to hold on to the identified part of device for the duration of the transfer and was transferred back to the wheelchair.

In an interview with RN #103, they stated resident #052 is unable to call for help due to their cognition. RN #103 stated for the situation mentioned above, the resident should not have been left unattended.

In an interview with ADOC #101, they stated for resident #052, the plan of care was not followed as the resident was left unattended on the toilet. [s. 6. (7)]

3. The licensee has failed to ensure that the provision of care set out in the plan of care was documented for resident #031.

A complaint and a CIS report was submitted to the Director related to the improper care of a resident that resulted in harm or risk to the resident. The CIS indicated that resident #031 was found in a specific condition. The resident's condition subsequently improved after administration of a specific treatment. At a specified time, the resident was found by ADOC #118 to again be in a specific condition and the resident's identified treatment device was empty.

During an interview with ADOC #118, they stated that once resident #031's condition at a specific hour improved, they asked RPN #136 to notify the physician about the incident and to continue monitoring the resident. ADOC #118 stated that they went back to the unit at a specified hour and was approached by a PSW who stated that they needed help with resident #031 because their identified treatment device was empty.

The Inspector reviewed resident #031's electronic medical record and was unable

to identify documentation related to the monitoring or care that resident #031 received between a specified amount of time. Record review of the progress notes by RPN #136 did not indicate that resident was monitored or had vital signs completed between the specified amount of hours.

During an interview with RPN #136, they stated that they assessed resident #031 frequently between a specified amount of hours and that the resident was stable during this time. RPN #136 stated that they did monitor the resident's vital signs, but acknowledged that they "may not have documented all the details of that day". RPN #136 stated that if the vital signs were not documented in a progress note, then the documentation was not complete.

During an interview with ADOC #118, they stated that, through the home's investigation, it was determined that resident #031 was being monitored by RPN #136 between specified amount of hours and that the resident was not in any acute distress during this time. They further stated that it is the home's expectation that if registered staff have taken vital signs, then it should be documented. ADOC #118 verified that there was no documentation related to the monitoring of the resident between a specified number of hours or the resident's specific vital sign levels during this time. [s. 6. (9) 1.]

4. The licensee has failed to ensure that resident #005, #011, and #054's plan of care was revised when their care needs changed.

The MOHLTC received a complaint related to multiple care area concerns related to resident #005. Review of the complaint indicated that the transfer sling that was used during transfers for resident #005 caused pain and discomfort.

An observation was conducted by Inspector #699 of resident #005 being transferred onto the toilet using a specific device. Resident tolerated transfer well, with no observed discomfort.

Review of the current care plan indicated that resident #005 required an alternate device for all transfers.

In an interview with PSW #139, they stated that they would look at the care plan for resident care need. They stated resident #005 was changed to a specific device for toileting by the PT many months ago however they could not recall when this change was made.

In an interview with PT #116, they stated resident #005 was a specific transfer due to their injury last year. They stated resident was using a special device at that time to prevent a specific symptom. PT #116 stated that resident #005 was assessed and changed to a specific device a few months ago. They confirmed that the care plan should have been updated with the specific device for toileting.

In an interview with RN #103 and ADOC #101, they both stated that resident #005 's care plan should have been changed at the time when the PT assessed them for the specific device.

b. A CIS report was submitted to the MOHLTC related to resident #011's transfer to hospital for an identified condition. In the hospital, resident #011 was diagnosed with identified conditions and later passed away in hospital.

A record review of resident #011's electronic medication administration record (MAR) and the record of physician's orders indicated that, resident #011 was treated for a specific diagnosis with an identified medication, as per Physician #138's orders. A review of the results of resident #011's report on a specific date, and diagnostic imaging records on a specific date, indicated a specific diagnosis.

In an interview, RN #137 identified the signatures on both reports to indicate that they were seen by Physician #138. RN #137 stated that in this situation, a physician would normally make necessary revisions to the resident's plan of care such as changes in medications and/or interventions to address the specific diagnosis, but could not confirm whether this was done for resident #011.

A record review of resident #011's progress notes, record of physician's orders, written plan of care, electronic medication administration record, and electronic assessments between a specified time period, did not include any revisions to resident #011's plan of care, or documentation as to why there were no revisions to their plan of care in relation to their symptoms or their above mentioned diagnostic assessments.

Furthermore, a record review of resident #011's progress notes indicated that resident #011 experienced a symptom and displayed increased behaviors during this time. On a specific date resident #011 was placed on isolation precaution for specific symptoms and then later was sent to hospital.

In interviews, RN #137 and ADOC #101 acknowledged that resident #011 continued to display symptoms of a specific diagnosis between specified dates, and that they were neither re-assessed nor their plan of care reviewed and revised to address this change in care needs related to these symptoms, or the results of the above mentioned diagnostic assessments.

c. This inspection was initiated to expand resident sample related to skin and wound weekly assessments and plan of care.

Record review of resident #054's most recent skin assessment indicated that the resident exhibited a specific altered skin integrity to an identified body area.

Record review of resident #054's current care plan indicated that resident #054 had a specific altered skin integrity that did not match what was documented in the skin assessment.

In an interview with ADOC #101, they stated that resident #054's care plan should be updated to reflect the most recent skin assessments. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written plan of care for each resident sets out clear direction to staff and others who provide direct care to the resident and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any written complaints that have been received concerning the care of a resident or the operation of the home are immediately forwarded to the Director.

The MOHLTC received a complaint from FM #200 related to the lack of specific care provided to resident #013 on two separate incidents. FM #200 indicated that they emailed their concerns to the home related to the above mentioned incidents on two separate days.

A record review of the home's policy titled Complaints Management Program, #XXIII-A-10.40, dated August 2016, stated that the Executive Director or designate is expected to immediately forward written complaints received by the home to the MOHLTC Critical Incident and Triage Team (CIATT) as per the Ministry regulations.

In interviews, ADOC #101 identified complaints raised in an email as being written complaints. Furthermore, in interviews, ADOC #101 and DOC #100 acknowledged that the complaint emails from FM #200 regarding resident #013, in relation to lack of specific care provided by RPN #152, and RPN #155 respectively, were not forwarded to the MOHLTC. [s. 22. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when the licensee receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices when assisting resident #052.

The MOHLTC received a complaint related to multiple care areas. Further review of the complaint indicated concerns related to resident #052 being left unattended when transferred on to the toilet.

Review of resident #052's progress note indicating that resident #052 was assessed to be appropriate for use of a specific device for transfers. The progress notes further indicated that staff should supervise the resident during the toileting process due to resident #052's cognitive impairment.

An observation of resident #052 being transferred for toileting was conducted by Inspector #699. The inspector observed resident #052 being transferred with a specific device with two staff present. During the transfer from wheelchair to toilet, resident #052 did not hold on to an identified part of the device and was not prompted to hold on to the identified part of the device by the staff.

In an interview with PSW #146, they stated that they should have used alternate device if the resident was not able to hold the identified part of the device. They further acknowledged that it was not safe to use the specific device for resident #052.

In an interview with RN #103, they stated the criteria for using the specific device is for the resident to be able to weight bear, hold the identified part of the device, and follow commands. They stated that resident #052 should not have been transferred if the resident was not holding onto the identified part of the device.

In an interview with PT #116, they stated the criteria for using a specific device would be as follows:
-Weight bear;
-follow instructions; and
-maintain a hold during specific device process, and not let it go.

They further stated the transfer should not be completed if the resident is unable to hold on to the arm bars of the specific device.

Review of the home's policy titled "Transfers using Specific device", policy VII- -G-20.30(m), last revised April 2019, indicated the criteria to determine that a resident would require the use of an alternate transfer device in place of a specific device if he/she exhibits one or more of the following:
-cannot weight bear;
-is uncooperative, aggressive or abusive during transfers;
-requires moving from a supine position; and
-is unable to follow directions.

In an interview with ADOC #101, they stated if a resident is not able to follow commands or hold onto the arm bars of the specific device, the transfer should not happen. ADOC #101 acknowledged that resident #052 was not transferred safely from their wheelchair to the toilet. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant.

The MOHLTC received a complaint from FM #200 related to the lack of specific care provided to resident #013 on two separate incidents.

A record review of the home's policy titled Complaints Management Program,

#XXIII-A-10.40, dated August 2016, stated that if a written concern/complaint is received by the home, the Executive Director or designate is expected to conduct and document an internal investigation using the Complaint Record Form including the requirements outlined in r. 101 (2) (a-f) as above, and log the written complaint with a summary on the Weekly Operational Review (WOR) Complaint Tab.

In an interview, ADOC #101 identified complaints raised in an email as being written complaints.

A review of two emails sent by FM #200 to DOC #100, indicated requests for meetings concerning two identified incidents where resident #013 failed to receive appropriate care resulting in them experiencing a specific symptom for an extended period of time.

Review of the home's complaints management program from 2017, did not contain any records related to the above-mentioned emails.

In expanding the scope, another written complaint related to a family member's complaint about a PSW speaking roughly with a resident was identified. It stated that the investigation was inconclusive and that a conference was arranged with a family. No further information as required by the policy titled Complaints Management Program was included.

In an interview, DOC #100 and ADOC #101 stated that FM #200's complaints, and the written complaint were addressed through fact finding, investigations and/or meetings. DOC #100 acknowledged that the home had not kept a documented record as required by the home's policy in relation to the complaints from FM #200, and the written complaint and their subsequent meetings, actions and responses. [s. 101. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a documented record is kept in the home that includes the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response, and any response made in turn by the complainant, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written policy that deals with when balcony doors must unlocked or locked to permit or restrict unsupervised access to those areas by residents.

This inspection was initiated by Inspector #699 when a balcony door was noted to be propped open with a chair on the second floor.

Observations conducted by Inspector #699, it was noted on specific days and times, the balconies were unlocked and unsupervised on the second and third floor.

In separate interviews with PSW #149 and RPN #150, they stated the balcony doors should be locked when unsupervised.

Record review of the home's policy titled "Door Safety and Security, policy VII-H-10.10, last revised April 2019, did not indicate any provisions for when balcony doors can be unlocked to provide access to the balcony.

In an interview with Environmental Supervisor (ES) #145, they stated they had a schedule when the balcony doors can be opened and locked. ES #145 was unable to provide Inspector #699 with a written policy related to when the balcony doors can be unlocked and locked for resident access. [s. 9. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written hot weather-related illness prevention and management plan for the home that meets the needs of the residents was implemented when required to address the adverse effects on residents related to heat.

The MOHLTC received a complaint related to a resident room being too hot during a specific week.

Review of the heat warnings issued by Toronto's Medical Officer of Health, as per the City of Toronto, indicated that a heat warning was issued for a specific week, and an extended heat warning was issued for a specific week.

The home's hot weather-related illness prevention and management plans in place during September 2017 and at the time of inspection are chronologically listed below:
- A policy titled Hot Weather - Management of Risk:
#VII-G-10.10 revised on November 2015, and #VII-G-10.30 revised on April 2019
-Heat Contingency Protocols:
#VII-G-10.10 (a) dated July 2015, and #VII-G-10.30 (a) dated April 2019
-Air Temperature Log:
#VII-G-10.10 (c) dated September 2016, and #VII-G-10.30 (c) dated April 2019

A review of the above policies indicated that maintenance or registered staff are required to record the outdoor temperature, indoor temperature, and humidity percentages from various locations within the building daily between 1100hrs and 1500hrs, several times a day whenever a hot weather alert is in effect. In addition, the alert level should be calculated, and the charge nurse and all departments should be informed of the heat contingency protocols to be implemented.

A review of the home's Air Temperature Log for a specific period of time from unit 2A indicated that the majority of readings were taken only once a day before 1100hrs. Air Temperature Logs for a specific period of time, from units 2A and 3A, indicated the same issues in addition to a high number of humidity readings being recorded as "low" instead of identified numerical percentages. None of the documents indicated the calculated or implemented alert levels.

In an interview, ES #145 and ADOC #101 confirmed that maintenance staff record the temperatures and humidity levels taken from the nursing stations every morning on each unit and acknowledged that taking the recordings only once in the mornings, taking them before 1100hrs, and failing to record numerical percentages of the indoor humidity levels was neither best practice, nor consistent with the home's hot weather-related illness prevention and management plan. ES #145 further acknowledged that this may result in not being able to implement appropriate interventions for residents assessed to be at high risk for heat related issues. [s. 20. (1)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that when approval for admission to a home is withheld, the licensee shall give to the appropriate placement coordinator, a written notice setting out a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; an explanation of how the supporting facts justify the decision to withhold approval.

A complaint was submitted to the MOHLTC alleging that a detailed letter explaining the home's decision to withhold approval for applicant #012 was received by Placement Coordinator #151 from the home; however, details were not explained in the letter. In an interview, PC #151 stated that an updated letter was requested from the home on multiple occasions with no response or updated letter sent by the home. PC #151 also stated that a detailed rejection was reportedly sent, but was never received by them.

A record review of the referral management system's notification log in the home indicated that a referral was made for applicant #012, a home visit was arranged by the home and the referral was refused by SW #111, citing lack of nursing expertise. A second request was made by PC #151 for a more detailed rejection letter, followed by another request a later date. A detailed rejection letter was stated to have been sent by SW #111 and PC #151 requested for it to be re-sent as it had not been received, and a letter was refaxed by SW #111.

A record review of applicant #012's rejection letter indicating receipt by the Placement Coordinator #151 stated that the home did not have the necessary resources to meet applicant #012's care requirements due to lack of nursing expertise, lack of physical facilities to meet care requirement, and that circumstances existed which are provided for in the regulations as being a ground for withholding approval. It further stated that based on the facts, the application could not be approved due to safety and security concerns for applicant #012 and others. The letter did not provide a detailed explanation of supporting facts related to the home, and the applicant's condition and requirements for care and how these facts justified the decision to withhold approval for admission.

In an interview, SW #111 stated that they had kept re-sending the same letter to PC #151 without updating it as they were unclear about PC #151's requests. SW #111 also acknowledged that the identified withhold approval letter did not provide

supporting facts related to the home and applicant #012's conditions and requirements for care. Furthermore, it did not include supporting facts, including the outcomes and assessment resulting from the home visit with applicant #012 justified the decision to withhold approval. [s. 44. (9)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that weekly wound assessments were completed for resident #005.

The MOHLTC received a complaint on May 24, 2017 related to multiple care area concerns related to resident #005. Review of the complaint indicated that resident #005 had altered skin integrity to an identified body area and family was not informed.

Record review of resident #005's progress notes indicated that the resident was noted to have altered skin integrity to an identified body area and a treatment was applied.

Record review of resident #005's treatment administration record (TAR) indicated that the resident received the following treatment during specific months for their altered skin integrity to an identified body area.

Further review of the TAR indicated that the treatment was discontinued on a specific date.

Record review of resident #005's skin assessment in PointClickCare (PCC) revealed that only four skin assessments were completed.

Further review of the resident #005's clinical health record did not indicate any further skin assessments were completed related to their altered skin integrity to an identified body area.

In an interview with RN #103, they stated that if a resident has altered skin integrity, weekly skin/wound assessments would be completed until the altered skin integrity is healed. RN #103 acknowledged weekly wound assessments should have been completed for resident #005.

In an interview with ADOC #101, they stated weekly skin and wound assessments should be completed for all residents exhibiting altered skin integrity. ADOC #101 acknowledged that for resident #005, the weekly skin assessments were not completed. [s. 50. (2) (b) (iv)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(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. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure for resident #005 who was demonstrating responsive behaviours, that actions were taken to respond to their needs, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The MOHLTC received a complaint related to multiple care area concerns related to resident #005. Review of the complaint indicated that the police were called on resident #005 when a staff member alleged that the resident hit them during care, and that family were unaware resident was exhibiting responsive behaviours.

Record review of progress notes indicates that resident #005 exhibited specific responsive behaviours towards staff on three occasions.

Record review of the progress note indicated that during care, resident #005 hit a PSW. The PSW subsequently then called the police on the resident. Further review of the progress notes did not indicate if resident #005 was assessed for their behaviour or put on any behavioural monitoring tools.

Record review of resident #005's care plan at the time of the incident, indicated

the following interventions for resident #005's responsive behaviours:
-Monitor mood patterns and document signs and symptoms of depression, anxiety, sad mood as per facility behaviour monitoring protocols;
-Spend time talking tor resident, family, encourage to express feelings.

Further review of resident #005's care plan after the incident, showed the same above mentioned interventions with no revisions or changes to the interventions.

In an interview with PSW #147, they stated that resident #005 had specific responsive behaviours towards staff. They further stated that they would involve the nurse to intervene with the behaviours.

In an interview with RN #103, they stated if a resident was exhibiting specific responsive behaviours, they would send a referral to the behavioural support outreach (BSO) team, complete a dementia observation system (DOS) tool, notify the physician, assess the resident and care plan would be reassessed with behavioural triggers. RN #103 could not recall if resident #005 was monitored after the incidents of a specific responsive behaviour.

Review of the home's policy titled "Responsive Behaviour – Management", policy number VII-F-10.20, last revised October 2016 showed that registered staff would conduct and document an assessment of the resident experiencing responsive behaviours to include:
-Completing behavioural assessments based on resident need, including but not limited to: DOS, behavioural assessment tools, depression scale, mini mental, Cohen-Mansfield;
-Complete an electronic responsive behaviour referral to the internal BSO Lead/ designate when there is a new, worsening, or change in responsive behaviour.

In an interview with ADOC #101, they stated if a resident was exhibiting verbal or physical aggression, it would be expected to re-approach resident, consider different strategies and a referral to BSO if needed. They further stated that for resident #005, there was no DOS monitoring or BSO referral made for the resident indicating that resident was assessed in response to their responsive behaviour.

The severity of this finding was a level 2, indicating potential harm. The scope was a level 2, indicating the issue was related to two of three residents reviewed. A review of the home's compliance history was a level 3 , indicating previous non-

compliance to the same subsection in the last 36 months. According to the judgement matrix, a compliance order (CO) is warranted, however, it has been confirmed through the inspection and the home's compliance history since the time of these incidents, that non-compliance related to O.Reg 79/10, r. 53(4)(c), has been addressed and rectified by the home. A written notification (WN) is being issued. [s. 53. (4) (c)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff who provide direct care to residents, are provided training in pain management, including recognition of specific and non-specific signs of pain.

The MOHLTC received a complaint about lack of staff training related to the management of resident #013's specific symptoms.

A review of the home's 2017 documentation of staff names who had completed the online management training related to the specific symptom, provided by DOC #100, did not include the names of RPN #152 or RPN #154. Both staff members were identified to have provided care to resident #013.

In an interview, DOC #100 stated that they were unable to provide further documentation to indicate that they had completed this training.

The severity of this finding was a level 3, indicating actual harm. The scope was a level 2, indicating the issue was related to two of three residents reviewed. A review of the home's compliance history was a level 2, indicating previous non-compliance to a different subsection in the last 36 months. According to the judgement matrix, a compliance order (CO) is warranted, however, it has been confirmed through the inspection and the home's compliance history since the time of these incidents, that non-compliance related to O.Reg 79/10, r. 221. (1) 4., has been addressed and rectified by the home. A written notification (WN) is being issued. [s. 221. (1) 4.]

Issued on this 10th day of September, 2019 (A2)

[redacted]

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by PRAVEENA SITTAMPALAM (699) - (A2)
Inspection No. / No de l'inspection :	2019_780699_0011 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	009963-17, 012192-17, 022806-17, 002983-19, 004908-19, 005285-19, 009086-19 (A2)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 10, 2019(A2)
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Fieldstone Commons Care Community 1000 Ellesmere Road, SCARBOROUGH, ON, M1P-5G2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lorraine Gibson

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 10th day of September, 2019 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by PRAVEENA SITTAMPALAM (699) - (A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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Service Area Office / Bureau régional de services : Toronto Service Area Office