Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 16, 2021	2021_642698_0015	023054-20, 009231-21, 011164-21, 011654-21, 012393-21	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

ORALDEEN BROWN (698)

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): July 30, August 3, 4, 6, 9-13, and 16-20, 2021.

The following Complaint intakes were inspected during this inspection:
Log #023054-20 related to Infection Prevention and Control (IPAC); #009231-21, #011164-21 and #011654-21 related to multiple care areas; and #012393-21 related to alleged abuse.

Off-site interview and record reviews were conducted on August 12, 2021.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Directors of Care (ADOCs), Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Physiotherapist (PT), Manager of Environmental Service (MES), Personal Support Workers (PSWs), residents and family members.

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

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Safe and Secure Home
Skin and Wound Care

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

- **3 WN(s)**
- **0 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

A complaint was made to the Director, relating to the resident being served a food product they were allergic to, despite a documented allergy.

Record review indicated that resident's allergies were documented in the plan of care upon admission.

Interview with the PSW indicated that they were aware of resident's care plan contents and proceeded to approach them with the allergen.

Sources: electronic records, home's investigation notes, complaint binder, policy, staff interviews. [s. 6. (7)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the 24-hour admission care plan for a resident included any risk of falling, and interventions to mitigate the risk.

A complaint was made to the Director relating to multiple care areas.

The resident was admitted to the home, sustained a fall twenty four hours later and was sent to hospital for assessment.

On the day of admission, a conference was held to create the admission care plan and no falls risk interventions were put into place.

Investigation notes indicated that there was a gap in communication between shifts regarding the resident's plan of care.

The plan of care policy required that the nurse complete the initial 24-hour electronic care plan assessment and personalization of the care plan within 24 hours of the resident moving in.

The RPN indicated that they were aware of resident's risk for falls and did not initiate interventions or communicate the risk during shift exchange report.

Sources: electronic health records, home's investigation notes, complaint binder, policy #VII-G-30.10 and staff interviews. [s. 24. (2) 1.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

A Critical Incident System (CIS) report was submitted to the Director related to an incident of alleged physical abuse of a resident by staff. The CIS was submitted to the Director approximately three months after the alleged incident took place.

Care was being provided for a resident when they experienced a change in condition. No falls were identified by the home and the resident was sent to hospital for further investigation. Resident returned five days later with injuries. The home did not suspect abuse or improper care upon the return from hospital after an internal investigation and failed to submit a CIS/complaint report regarding the injuries.

Interview with DOC indicated a complaint was made by the Power of Attorney and that during the investigation, the resident did not sustain any falls or injuries prior to being sent to hospital; Abuse was not verified and the injuries were not reported to the Director when they did not appear to have occurred in the home. DOC indicated that a written complaint was sent to the Director and a CIS report was not submitted within 10 days.

Sources: CIS report, home's video footage, policy, complaint binder, and staff interviews. [s. 104. (2)]

Issued on this 24th day of September, 2021

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

Original report signed by the inspector.