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
Apr 20, 2022	2022_650565_0008	003478-21, 017535-21, 019329-21, 019999-21, 001331-22, 003351-22	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

MATTHEW CHIU (565), NITAL SHETH (500)

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): March 15-18, 21-25, and 28, 2022.

The following intakes were completed in this complaint inspection:
- Logs #003478-21, #019329-21 were related to alleged abuse and neglect;
- Log #017535-21 was related to Residents' Bill of Rights and menu planning;
- Logs #019999-21, #001331-22 were related to alleged abuse and neglect, and improper care and treatment of residents; and
- Log #003351-22 was related to alleged improper care of a resident.

The Written Notification and Voluntary Plan of Correction issued under LTCHA, 2007 S.O. 2007, c.8, s. 19 (1) for resident #009 was identified during concurrent inspection #2022_766500_0009.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Directors of Care (ADOCs), Nurse Manager (NM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Assessment Instrument Minimum Data Set (RAI-MDS) Coordinator, Residents and Family Coordinator (RFC), Physician, Housekeeping Staff, Residents, and Family Members.

During the course of the inspection, the inspectors observed the home’s infection prevention and control (IPAC) practices, resident and staff interactions, and reviewed clinical health records, relevant policies and procedures, and other pertinent documents.

Inspectors Reji Sivamangalam (#739633) and Kwesi Douglas (#736409) attended this inspection during orientation.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

8 WN(s)
7 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff collaborated with the Behavioural Support Ontario (BSO) lead in the assessment of resident #003's responsive behaviours.

The Ministry of Long-Term Care (MLTC) received a compliant alleging medication was administered without a consent.

Resident #003 was admitted to the home and assessed to have responsive behaviours. On one day, a medication was administrated to the resident in response to their responsive behaviours. The resident was referred to the interdisciplinary team the same day, but the referral was never completed and closed by the staff without any assessment.

The home's policy required the nurse to complete an electronic referral to the interdisciplinary team and the RAI-MDS Coordinator confirmed that the referral should have been addressed.

Sources: Resident #003's assessments, progress notes, home's policy "Responsive Behaviour Management, #VII-F-10.10"; interviews with the RAI-MDS Coordinator and

others. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the resident’s substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident #003’s plan of care.

Resident #003 was prescribed with a medication for their responsive behaviours. This medication was administered to the resident on 22 dates in a three-month period. Subsequently, this medication order was changed, and later it was held as requested by the resident's substitute decision-maker (SDM). The SDM previously requested the home not administer this medication approximately a week after it was first administered to the resident, and declined to consent to this medication on several occasions. There was no documentation of consent by the SDM for this medication.

The home’s policy indicated that the nurse should obtain consent for any new treatment and review the treatment with the resident or SDM prior to its initiation.

The physician confirmed that they would not initiate any medication without the SDM’s consent and was not sure how this medication was ordered and administered to resident #003.

Sources: Resident #003’s physician’s orders, Mediation Administration Record (MAR) progress notes, home's policy "Authorization of Personal Assistance Consent to Treatment, #VIII-B-10.40"; interviews with the SDM, physician and other staff. [s. 6. (5)]

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 staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
- the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #009 was protected from abuse by anyone and resident #004 was not neglected by the licensee or staff.

a. Section 5 of the Ontario Regulation 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents."

The MLTC received a complaint alleging neglect of resident #004 by registered staff.

Towards the end of a shift, RPN #112 did not attend and assess the resident when informed by the SDM of a change in resident #004's health condition. RPN #112 reported

to the next shift RN #113 about resident #004. RN #113 did not attend resident #004 immediately. Several hours later, RN #113 was called by the SDM, due to further change in the resident's health condition, and assessed the resident. The resident was found with a significant change in condition. RPN #112 confirmed that they reported to RN #113, and left the home without attending the resident, assuming that RN #113 would attend the resident. RPN #112 and RN #113 neglected to assess resident #004 for a significant change.

The DOC confirmed that RPN #112, and RN #113 neglected resident #004.

Sources: Resident #004's care plan, progress notes, complaint letter from the SDM, investigation record; interviews with the SDM, RPN, DOC and other staff.

b. Section 2 (1) of the Ontario Regulation 79/10 defines sexual abuse as "Any non-consensual touching, behaviour or remark of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

Resident #009 reported that someone entered their room and approached the resident in bed. They demonstrated inappropriate sexual behaviours towards resident #009. Upon assessment, resident #009 was found with injuries and they were in emotional distress as a result of this incident. Later, it was found that resident #008 had entered resident #009's room, and resident #009 had requested resident #008 to leave their room.

The DOC confirmed the incident of sexual abuse.

Sources: CIS (2906-000019-21); interview with the DOC and other staff. [s. 19. (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 residents are protected from abuse by anyone and are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: 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:
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #003's care plan included any potential behavioural triggers and safety measures to mitigate the risk that may pose to others.

The MLTC received a compliant alleging medication was administered without a consent.

Resident #003 was admitted to the home and exhibited responsive behaviours. The initial nursing assessment on the admission day indicated that resident #003 might pose risks to others. The goals and interventions to address the resident's responsive behaviour were not initiated until nine days later.

The home's policy indicated that a care plan must be developed within 24 hours of admission for each resident and it must include risks the resident may pose to others, including behavioural triggers and safety measures to mitigate those risks. The plan of care must include the planned care, for the resident, the goals the care is intended to achieve and clear direction to team members and others who provide direct care to the residents.

The RAI-MDS Coordinator confirmed that the 24-hour care plan should have developed to address resident #003's responsive behaviours.

Sources: Resident #003's plan of care, home's policy "Documentation-Plan of Care & Care Plan Definitions, #VII-C-10.90(e)"; interview with the RAI-MDS Coordinator. [s. 24. (2) 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 the care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
- Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks, to be implemented voluntarily.

WN #4: 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 techniques when assisting resident #002.

Resident #002 required a mechanical lift for transfer. Staff indicated safe transferring techniques included staff guiding the resident's body to prevent injury.

At the beginning of a shift, the resident's primary PSW, together with other staff members, assisted the resident's care and transferred the resident using the mechanical lift. The primary PSW was operating the lift and other staff members were assisting by guiding and positioning the resident. During the transfer, staff missed observing and guiding part of the resident's body. As a result, the resident sustained an injury.

Sources: The resident's progress notes, care plan; interviews with the PSW, RPN and ADOC. [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 #5: The Licensee has failed to comply with O.Reg 79/10, s. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004 received end-of-life care in a manner that met their needs.

The MLTC received a complaint alleging neglect of resident #004 by registered staff.

Resident #004 was provided end-of-life care and did not receive care based on their plan of care as explained below:
- Two registered staff did not attend and assess resident #004 when there was a significant change in their health condition.
- A registered staff was not aware of the resident's needs related to pain medication administration.
- The medication order was not clear based on the SDM's and physician's conversation.

The physician changed the orders for pain medication after they spoke with the SDM, and the orders were not processed until the SDM made a request the next day.

The home's policy indicated internal and external resources are to ensure that the resident receives the best possible pain control, resources and supplies are available, support the use of pain pumps if appropriate and provide education to nurses on the use of equipment.

The DOC confirmed that the resident did not receive end-of-life care in a manner that met their needs.

Sources: Resident #004's plan of care, progress notes, complaint letter from the SDM, investigation record, home's policy "Palliative Care-Care of the Resident, #VII-G-30.40"; interviews with the SDM, RPN, NM, DOC and other staff. [s. 42.]

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 every resident receives end-of-life care when required in a manner that meets their needs, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to ensure that supplies, equipment and devices were readily available at the home to meet the nursing and personal care needs of resident #004.

The SDM informed the physician of their preference of using specified supplies for administering a medication.

The next day, an order for the change in the medication dosage was made by the physician. This order and another order for the use of the specified supplies were not processed until the day after. The unit nurse was not aware about the administration of the medication using the above mentioned supplies. The NM had to find the required supplies and assist the unit nurse to administer the medication to resident #004.

The NM and the DOC confirmed that the home should have required supplies, equipment and devices readily available for the resident's care.

Sources: Resident #004's plan of care, progress notes, complaint letter from the SDM, investigation record, home's policy; interviews with the SDM, RPN, NM, DOC and other staff. [s. 44.]

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 supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents, to be implemented voluntarily.

WN #7: 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

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 residents #001 and #010, who were at risk of altered skin integrity, received a skin assessment by a member of the registered nursing staff upon return from hospital.

a. Resident #001 was exhibiting altered skin integrity in multiple areas of their body. The resident was transferred to the hospital and returned to the home seven days later. Upon their return from hospital, they did not receive any skin assessment by registered staff.

b. Resident #010 was exhibiting altered skin integrity. The resident was transferred to the

hospital and returned to the home the next day. Upon their return from hospital, resident #010 did not receive a skin assessment from registered staff.

The ADOC indicated a resident at risk of altered skin integrity should receive a skin assessment by registered staff on the same day upon their return from hospital. Residents #001 and #010 should have received a skin assessment from registered staff upon return from the hospital.

When residents #001 and #010 did not receive a skin assessment by the registered nursing staff upon return from hospital, there was a potential risk of worsening altered skin integrity for the residents.

Sources: The residents' progress notes, skin and wound evaluation V6.0, head to toe assessment V2.0; interview with the ADOC. [s. 50. (2) (a) (ii)]

2. The licensee has failed to ensure that resident #010, who was exhibiting altered skin integrity, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Staff stated when resident exhibiting altered skin integrity, the area should be assessed by registered staff using the home’s skin and wound evaluation instrument, and reassessed at least weekly until healed. The home used the same assessment tool for the initial and weekly assessment, and registered staff might also use progress notes to document their weekly assessments.

Resident #010 was exhibiting altered skin integrity. An alteration was noted on the resident’s skin and treatment was given the same day. Several days later, it was documented as a pressure ulcer. The resident did not receive a skin assessment by registered staff using the home’s skin and wound evaluation instrument until approximately six weeks later, which showed the same pressure wound.

Sources: The resident’s progress notes, skin and wound evaluation V6.0; interviews with the ADOC and staff. [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that resident #001, who was exhibiting altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff.

Resident #001 was exhibiting altered skin integrity in multiple areas of their body during a three-month period. Six of the alterations located on different body areas were not assessed at least weekly in multiple periods, ranging from 10 days to over a month, by a registered staff as required. During this three-month period, the available assessments indicated some of the wounds worsened, deteriorated or remained at the same stage.

Sources: The resident's progress notes, skin and wound evaluations V6.0; interviews with the ADOC and staff. [s. 50. (2) (b) (iv)]

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) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(ii) upon any return of the resident from hospital; and
(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,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
17. Drugs and treatments. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of resident #003's drugs and treatments.

The MLTC received a compliant alleging medication was administered without a consent.

Resident #003 was admitted to the home and exhibited responsive behaviours. The resident was prescribed with a medication for their responsive behaviours the day after their admission. There was no assessment available in the resident's plan of care completed by the physician or registered nursing staff.

The home's policy indicated that the registered nursing staff were to completed behavioural assessment based on the resident's needs, including Behavioural Assessment Tool (BAT), and provide treatment and interventions as required. The interprofessional team were to explore non-pharmacological interventions whenever possible. The physician was to assess and evaluate the medical plan of care including the use of antipsychotics to determine the most effective treatment strategy.

The physician confirmed that they should have tried non-pharmacological approaches before initiating a medication to manage the resident's responsive behaviours. The DOC verified that for newly identified responsive behaviour an assessment should have completed.

Sources: Resident #003's plan of care, home's policy "Responsive Behaviour Management, #VII-F-10.10"; interviews with the SDM, physician, DOC and other staff. [s. 26. (3) 17.]

Issued on this 22nd day of April, 2022

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

Original report signed by the inspector.