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: May 8, 2023	
Inspection Number: 2023-1390-0005	
Inspection Type: Follow up Critical Incident System	
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	
Long Term Care Home and City: Fieldstone Commons Care Community, Scarborough	
Lead Inspector Henry Chong (740836)	**Inspector Digital Signature** Henry A Chong Digitally signed by Henry A Chong Date: 2023.05.09 13:58:00 -04'00'
Additional Inspector(s) Yannis Wong (000707)	

INSPECTION SUMMARY

The inspection occurred on the following date(s): April 24-27, 28 (offsite) and May 1-3, 2023

The following intake(s) were inspected:

- Intake: #00017892 - Follow-up related to transferring and positioning techniques
- Intake: #00019554 - [CI: 2906-000012-23] - Medication incident/adverse drug reaction
- Intake: #00022797 - Follow-up related to Infection Prevention and Control
- Intake: #00084421 - [CI: 2906-000016-23] - Fall with injury
- Intake: #00084642 - [CI: 2906-000018-23] - Staff to resident neglect

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2022-1390-0002 related to O. Reg. 79/10, s. 36 inspected by Henry Chong (740836)

Order #001 from Inspection #2023-1390-0003 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Henry Chong (740836)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that when there were reasonable grounds to suspect that neglect of a resident occurred, that it was immediately reported to the director.

Rationale and Summary
The home received a written complaint from a resident's Substitute Decision Maker regarding neglect of the resident by staff. An investigation was completed by the home in which the allegation was not substantiated.

The home reported the incident to the Director one day after the written complaint was received. An ADOC stated that the incident should have been reported immediately but did not.

Sources: CIS report 2906-000018-23; and interview with ADOC.

[740836]

WRITTEN NOTIFICATION: Medication management system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)

The licensee has failed to comply with the home's policies, developed for the medication management system to ensure accurate administration of drugs used in the home.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that the home's medication pass policy related to accurate administration was complied with.

Specifically, a staff member did not comply with the home's policy "The Medication Pass," last revised April 2021, that directed staff to verify the right medication was being administered.

Rationale and Summary
A Registered Nurse (RN) administered a resident's scheduled medications on a specified date. The nurse was unable to confirm post administration which medication they had administered to the resident, including potentially administering a medication that was not ordered for the resident. A medication incident was completed.

The licensee's policy "The Medication Pass" directed staff to ensure the rights of medication are completed prior to administration, including verifying the right medication. Review of the home's investigation notes indicated that the home expected the staff member to compare the medication name on the medication administration record (MAR) with the name on the actual medication item to ensure the right medication is on hand prior to administering it to the resident. The RN could not substantiate that they had checked the correct medication prior to administration and the DOC confirmed that the home's policy was not followed.

The staff's failure to verify the right medication was being administered put the resident at risk of potential health issues.

Sources: CIS #2906-000012-23; clinical records; investigation notes; home's The Medication Pass (policy 3-6, last revised April 2021); medication admin audit report; and interviews with the RN and DOC.

[000707]