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
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Public Report

Report Issue Date: January 29, 2025

Inspection Number: 2025-1390-0001

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP

Long Term Care Home and City: Fieldstone Commons Community, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 20, 21, 22, 23, 24, 27, 28, 29, 2025

The follow up intake was inspected:

- Intake: #00133356 related to Compliance Order Follow-up #001 under Inspection #2024-1390-0005

The following Critical Incident System (CIS) intake(s) were inspected:

- Intake: #00131563/CIS#2906-000039-24 related to injury of unknown cause
- Intake: #00136226/CIS#2906-000001-25 related to falls prevention and management

The following CIS intakes were completed during this inspection:

- Intake: #00129726/CIS#2906-000036-24 related to falls prevention and management
- Intake: #00131055 /CIS#2906-000038-24 related to falls prevention and management

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The following Complaint intake (s) were inspected:

- Intake: #00132649 related to withholding approval for admission
- Intake: #00135795 related to resident care

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1390-0005 related to O. Reg. 246/22, s. 268 (4) 1. ii.

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure the resident written plan of care provided clear directions to direct care staff on the application of their footwear.

The plan of care did not specify frequency or when the intervention was to be applied. The resident was found wearing inappropriate footwear.

Two Personal Support Workers understood the footwear were to be applied only when the resident was in bed. The Assistant Director of Care confirmed the footwear are to be applied at all times and acknowledged that the care plan was unclear.

Sources: Observation; residents clinical records; and interviews with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
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

The licensee has failed to ensure that the staff and others involved in the different aspects of care collaborated with each other in the completion of the resident's x-ray.

The physician ordered an x-ray on two dates and both orders were not completed in a timely manner. Two Registered Nurses, and ADOC were not aware of the reason for the delay in obtaining the resident's x-ray in a timely manner.

Sources: Review of residents clinical records; and interviews with staff.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

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

Specifically, the resident's call bell was not within their reach while they were in bed, placing them at risk of attempting to get up on their own and sustaining a fall.

Sources: Observations; residents clinical records; and interviews with staff.

WRITTEN NOTIFICATION: Licensee Consideration and Approval

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (7) (b)
Authorization for admission to a home
s. 51 (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 50 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or

The licensee failed to demonstrate that they lacked the nursing expertise to manage applicant's care requirements. An applicant's approval for admission was withheld by the home because they claimed they did not have the nursing expertise to manage the applicant's responsive behaviours. The Behavioural Supports Ontario (BSO) Lead and Social Worker identified that the home had experience with the specific behaviours outlined in applicant's file and that the Home would be able to manage their care requirements.

Sources: Interviews with staff; applicant's assessments; and bed refusal letter.

WRITTEN NOTIFICATION: Written Notice if Licensee Withholds Approval

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (9) (d)
Authorization for admission to a home
s. 51 (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(d) contact information for the Director.

The licensee failed to ensure that the contact information for the Director was provided in the written notice withholding approval of admission to applicant. The home's letter withholding admission to the applicant, did not contain the contact information for the Director.

Sources: Letter withholding approval of admission of applicant; and interviews with staff.