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

Original Public Report

Report Issue Date: March 1, 2024
Inspection Number: 2024-1390-0001
Inspection Type: Proactive Compliance Inspection
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP
Long Term Care Home and City: Fieldstone Commons Community, Scarborough

Lead Inspector	**Inspector Digital Signature**
Susan Semeredy (501)	Susan L Semeredy Digitally signed by Susan L Semeredy Date: 2024.03.04 09:34:12 -05'00'

Additional Inspector(s)
Cindy Cao (000757)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 15, 16, 20, 21, 22, 23, 26, 27, 2024

The following intake(s) were inspected:

- Intake: #00109035 - Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Residents' and Family Councils

Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary.

The licensee has failed to ensure a resident was reassessed, and their plan of care was reviewed and revised when there were changes to their care needs.

Rationale and Summary

A resident's care plan indicated they required extensive assistance with an activity of daily living (ADL).

During an interview, the resident revealed that they only required set up help with this ADL. A Personal Support Worker (PSW) and Registered Nurse (RN) confirmed that the resident only required set up help and the RN acknowledged the resident's care plan should have been updated to reflect the resident's current care needs.

The resident's care plan was revised and updated.

Failure to reassess the resident's care needs and revise their plan of care posed minimal risk to the resident.

Sources: The resident's clinical records, interviews with the resident, a PSW and an RN. [000757]

Date Remedy Implemented: February 21, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure the current version of the visitor policy was posted in the home.

Rationale and Summary

On February 15, 2024, during the initial tour of the home, the inspector observed the visitor policy was not posted in the home.

The Executive Director (ED) stated that the visitor policy was missing in the "Sienna Senior Living Key Documents" binder that was placed in the hallway of the main lobby of the home. The ED acknowledged that the visitor policy should have been included in the binder which contained documents to be shared with visitors and staff.

The inspector observed the visitor policy was placed in the "Sienna Senior Living Key Documents" later the day on February 15, 2024.

Failure to ensure the visitor policy was posted in the home prevented visitors from accessing the document for visiting directions and guidelines.

Sources: Observations on February 15, 2024 and interview with ED. [000757]

Date Remedy Implemented: February 15, 2024

WRITTEN NOTIFICATION: Food Production

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)
Food production
s. 78 (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 246/22, s. 78 (3).

The licensee has failed to ensure that all foods in the food production system were served using methods to prevent food borne illness.

Rationale and Summary
The home's policy titled Food Temperatures - Point of Service, XXIII-H-10.30 last revised June 2019 stated food temperatures will be taken at point of service prior to serving food to residents. Food temperatures must be a minimum of 140 degrees Fahrenheit (60 degrees Celsius) for hot food and no more than 40 degrees Fahrenheit (4 degrees Celsius) for cold food.

It was observed in a servery that a Food Service Worker (FSW) did not take the temperatures of the cold food that had been unloaded from the transport cart and placed on a bed of ice. The FSW did however write in the food temperature log that the cold salad was 4 degrees Celsius and stated that they do not take the temperature of the cold food because it is always 4 degrees Celsius and put on ice. When asked to take the temperature of the salad by the inspector, it was 5.6 degrees Celsius. The Director of Dietary Services (DDS) arrived in the servery and stated the temperature of all cold food items needs to be taken. Review of temperature logs for the previous three days, indicated all cold food was recorded being at 4 degrees Celsius.

Follow up interviews with the Registered Dietitian (RD) and DDS confirmed the temperature of cold food must be taken at the point of service.

Failing to take the temperature of food items and record them appropriately put residents at risk for food borne illness.

Sources: Observation, the home's policy and food temperature logs, and interviews with the Director of Dietary Service and other staff. [501]

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. iii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that the home's Continuous Quality Improvement (CQI) Initiative Report contained a written record of how, and the dates when, the results of the resident and family satisfaction survey for 2022 were communicated to members of the staff of the home.

Rationale and Summary
The home's CQI Initiative Report indicated that for 2023-24 their priority areas for quality improvement were partially based on the home's 2022 Resident and Family Satisfaction Survey results. The Executive Director (ED) who was also the Lead for the CQI acknowledged the report clearly indicted the dates the survey was shared to the Residents' and Family Councils but did not include how and the dates when the survey was communicated to the members of the staff of the home.

Sources: The home's CQI Initiative Report and an interview with the ED. [501]