Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 28, 2013	2013_122156_0007	H-001876-12	Complaint

Licensee/Titulaire de permis

MAPLEWOOD NURSING HOME LIMITED
500 QUEENSWAY WEST, SIMCOE, ON, N3Y-4R4

Long-Term Care Home/Foyer de soins de longue durée

CEDARWOOD VILLAGE
500 QUEENSWAY WEST, SIMCOE, ON, N3Y-4R4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

CAROL POLCZ (156)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 11, 12, 13, 17, 19, 2013

This inspection was in relation to Log H-001876-12 and also includes Log H-002135-12, H-002153-12, and H-002104-12

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Dietitian (RD), Food Services Manager (FSM), registered staff, Personal Support Workers (PSW's), dietary aides, and residents

During the course of the inspection, the inspector(s) reviewed resident clinical records, observed meal service, inspected the kitchen and production areas, and observed medication pass.

The following Inspection Protocols were used during this inspection:
Dining Observation

Food Quality

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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 O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the staffing plan provided for a staffing mix that is consistent with the residents' assessed care and safety needs and that meets the requirement set out in the Act and this Regulation.
As confirmed by the DOC on February 12, 2013, there is an inconsistency of staffing on the weekends vs. during the week. Four PSW's are scheduled for evening shift (2pm-10pm) in the home for each floor for Saturdays and Sundays. During the week (Monday to Friday), there is an additional PSW 'bath' person who also assists with feeding residents. The DOC confirmed that feeding is in the job routine of the bath person. Because there is not an additional person (bath person) available on the weekends, residents do not receive adequate assistance to support their care needs, have to wait to be fed or have food left in front of them while waiting for assistance. This was confirmed during observation by the inspector on Sunday February 17, 2013, in Dining room #2, the inspector observed one PSW feeding residents 007 and 013. At the same table, residents 008 and 009 were not provided their meals and waited for approximately 20-25 minutes without being served their meals or provided assistance in eating as there were not enough staff available to assist. During the course of the inspection, several PSW staff indicated that often they have to wait for up to half an hour to assist other residents and then have to reheat the food or that they have to go and get the food from the steam table because the dietary person has left to go serve in another dining room.
In addition to the current staffing mix, the home often runs short which would further leave residents without assistance. The PSW evening schedule was reviewed with the DOC and it was confirmed that from January 6, 2013 to February 3, 2013, the home was unable to replace shifts and therefore ran short of scheduled PSW evening shifts on 10 occasions, including two occasions on a weekend. [s. 31. (3) (a)]

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 the staffing mix is consistent with resident assessed care and safety needs and that meets the requirements set out in the Act and this Regulation, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home policy on Medication administration 6.0 was followed. The policy indicated that staff were to ensure that the resident takes all of the medication and document on the MAR if they don't. On two consecutive days, in two different dining rooms, the inspector observed an RN leave medication for residents 005 and 006 on February 12, 2013 and residents 003 and 004 on February 13, 2013 without observing to ensure all the medication was taken. [s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident was offered the planned menu items at each meal and snack. Residents were not offered the planned portion sizes of items. On February 13, 2013 in dining room #4, the portion size indicated on the therapeutic menu for minced lasagne was a #8 scoop, however, a #10 scoop was used instead. A #16 scoop was used for minced peas although a #12 scoop was indicated on the therapeutic menu. In dining room #2, a #10 scoop was used for both minced and puree lasagne although a #6 scoop was indicated for minced lasagne and a #6 scoop was indicated for puree lasagne.
On February 19, 2013, in dining room #2, the portion size was listed as a #6 scoop for puree baked beans, however, a #10 scoop was used. In dining room #4 a #12 scoop was used for the same item and a #16 scoop was used for puree bread although a #12 scoop was indicated on the therapeutic menu. [s. 71. (4)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (1) Every licensee of a long-term care home shall ensure that there is an organized food production system in the home. O. Reg. 79/10, s. 72 (1).

s. 72. (2) The food production system must, at a minimum, provide for,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

s. 72. (4) The licensee shall maintain, and keep for at least one year, a record of,
(c) menu substitutions. O. Reg. 79/10, s. 72 (4).

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that there was an organized food production system in the home. The production system used in the home was not organized to track leftovers or shortages although, as confirmed by the RD, the home has received several complaints of running short in the past. During the inspection, it was noted that one dining room ran out of cheese dreams at lunch on February 19, 2013 and ran out of pancakes for second helpings on February 12, 2013 (pancake Tuesday). The production system in the home was not organized to accurately guide food production. The recipe quantities did not match the amount to be produced according to the production sheets. Changes in residents and resident diets were not accounted for in terms of what to produce for each diet/texture as the same quantities were followed for over five weeks.
As confirmed by a cook, not all recipes were found to be followed, for example, the recipe for vegetable soup on February 19, 2013 indicated that fresh celery, carrots and onions were to be used, however, it was confirmed that ingredients were frozen and canned. The recipe was for 50 servings, however, the production sheet indicated that 95 servings were to be prepared. [s. 72. (1)]

2. The licensee failed to ensure that menu substitutions were documented on the production sheets. As confirmed by the home Registered Dietitian and Food Services Manager, the home currently does not document menu substitutions on the production sheets. Moreover, the home has not retained any production sheets and therefore documentation of substitutions could not be found. [s. 72. (2) (g)]

3. The licensee failed to ensure that records were maintained of all menu substitutions, and kept for at least one year. As confirmed by the home Registered Dietitian and Food Services Manager, the home has not retained any production sheets and therefore documentation of substitutions could not be found. [s. 72. (4) (c)]

4. The licensee failed to ensure that staff complied with the food production area cleaning schedules. Dietary staff indicated that the staff have the entire month to complete and sign the cleaning schedules for each month. The cleaning schedules for positions #2, #3, #5 and #6 were not completed at all for January 2013 and the cleaning schedules for positions #1 and #7 were incomplete for January 2013. On the first day of the inspection, February 11, 2013, the kitchen production areas including the floors, corners, walls and garbage pails were found to be very dirty. Several days later, the kitchen remained in the same state, as confirmed by the Food Services Manager on February 19, 2013. [s. 72. (7) (c)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in a medication cart that was secure and locked. As confirmed by the DOC and an RPN on February 13, 2013, the medication cart was to remain secure and locked at all times when not in sight. On two consecutive days, during the lunch meal on February 12 and 13, 2013, an RPN was observed leaving the medication cart unlocked and out of sight while administering medication in the dining room. [s. 129. (1)]

Issued on this 2nd day of April, 2013

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

Dawe Hoag, RN.