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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: April 05, 2024

Inspection Number: 2024-1028-0002

Inspection Type:
Proactive Compliance Inspection

Licensee: Maplewood Nursing Home Limited

Long Term Care Home and City: Maple Manor Nursing Home, Tillsonburg

Lead Inspector	**Inspector Digital Signature**
Tatiana McNeill # 733564	Tatiana McNeill Digitally signed by Tatiana McNeill Date: 2024.04.05 10:38:39 -04'00'

Additional Inspector(s)
Cassandra Taylor # 725
Rhonda Kukoly # 213
Dante De Benedictis # 000818 was also present during this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: March 14, 15, 18, 19, 20, and 21, 2024
The inspection occurred onsite on the following dates: March 18 and 19, 2024

The following intake was inspected:

- Intake: #00109701 - Proactive Compliance Inspection (PCI)

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

Skin and Wound Prevention and Management

Resident Care and Support Services
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
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Advice

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 43 (4)

Resident and Family/Caregiver Experience Survey

s. 43 (4) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in carrying out the survey and in acting on its results.

The licensee has failed to ensure the advice of the Residents' Council was sought in acting on the results of the Resident and Family/Caregiver Experience Survey.

Rationale and Summary

The three most recent Residents' Council meeting minutes did not include any reference to the results of the resident and family/caregiver experience survey. The Programs Manager, who was the Residents' Council assistant, stated by email, that

they did not recall reviewing the results of the 2022 survey with the Residents Council, and that they would be reviewing the results of the 2023 survey with the Residents' Council at the next meeting scheduled on March 26, 2024.

Sources: Residents' Council meeting minutes, and email communication with the Programs Manager. [213]

WRITTEN NOTIFICATION: Air Temperature

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 24 (1)

Air temperature

s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

Rationale and Summary

During a Proactive Compliance Inspection at the home, Inspector #733564 noted the air temperature in a resident home area to be cold.

Inspector noted the temperature in the resident home area to be 20 degrees Celsius.

In an interview, Maintenance Manager stated that the air temperature in the home was set for 22 degrees Celsius, with an app called Govee. Maintenance Manager stated that they monitor the air temperatures in the home with the app, and they were notified with an alert if a temperature goes below 22 degrees Celsius, or if the air temperature was too high. Administrator stated that they were also notified of these alerts.

Review of temperature monitored through the Govee app for 2023 noted the air temperature in some of the resident home areas to vary between 18 and 21.9 degrees Celsius.

There was risk to the residents when the home was not maintained at a minimum temperature of 22 degrees Celsius.

Sources: Observations in the home, review of the documentation of air temperatures for 2023, interview with Maintenance Manager, and interview with Administrator. [733564]

WRITTEN NOTIFICATION: General requirements

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee has failed to evaluate and update the falls prevention and management program, the skin and wound care program and the pain management program, in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, at least annually.

Rationale and Summary
The Administrator stated in an email, that they did not have written program evaluations for the falls prevention and management, skin and wound care and the pain management programs.

The Skin and Wound Program policy included skin assessment and identifying residents at risk for altered skin integrity, prevention of altered skin integrity, and procedures for each interdisciplinary role for residents with altered skin integrity, but did not include any direction or procedures for any other form of altered skin integrity. The Director of Care (DOC) said that the policy should include direction and processes for all forms of altered skin integrity, they were not aware that it did not and would be updating the policy.

There was risk when the programs were not evaluated annually, that the policies and procedures did not address or provide appropriate direction to staff to meet the needs of residents related to falls prevention and management, pain management, and skin and wound care.

Sources: NDM-3-239 Skin Care and Wound Management Program dated July 30, 2023, email communication with Administrator and interview with the DOC. [213]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to

the residents.

The licensee has failed to ensure that food and fluids served were at a temperature that was both safe and palatable to the residents.

Rationale and Summary
During a Proactive Compliance Inspection, a resident stated that the food served at meals was often cold.
Review of a temperature log sheet noted that all foods served at meals were within required temperature levels.

Review of home's Safety and Sanitization Policy last reviewed August 17 noted "7. All hot service food products are to maintain temperatures above 60 degrees C or 140 degrees F and all cold service foods are to maintain temperatures of 5 degrees C or 40 degrees F or lower prior to meal service."

In an interview, Nutrition Manager (NM) stated that the home used a SuziQ cart system to serve food to residents in two separate dining rooms. NM acknowledged that the staff were observed leaving the food uncovered in the SuziQ cart when going in between two dining rooms. NM stated that the staff had been instructed to cover the food between the two dining rooms to ensure the food served was safe and palatable to residents. Additionally, the NM stated that they had instructed the staff to recheck the temperatures of the food prior to serving the residents in the second dining room, but this process was not implemented at the time of the inspection.

By not ensuring residents were served food at palatable temperatures, they were placed at risk of experiencing unplanned weight loss and/or not enjoying the dining

experience.

Sources: Review of temperature log sheet, review of Review of home's Safety and Sanitization Policy last reviewed August 17, interview with a resident and Nutrition Manager.
[733564]

WRITTEN NOTIFICATION: Housekeeping

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

The licensee has failed to ensure that cleaning and disinfection of the resident care equipment was done in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Rationale and Summary
Observations completed in the home noted a Personal Support Worker (PSW) not sanitizing a piece of equipment between two resident's care.
In an interview, the PSW stated that they should have sanitized the equipment

between two resident's care.

Review of the home's Infection Prevention and Control manual noted that it did not include a policy and/or procedure for disinfecting medical equipment between resident use.

Administrator and Infection Prevention and Control (IPAC) Lead acknowledged that the home's Infection Prevention and Control manual did not include a policy and/or procedure for disinfecting medical equipment between resident use.

There was potential risk of cross contamination acquired infections when the PSW did not sanitize the equipment between two resident's care.

Sources: IPAC observations in the home, review of the home's Infection Prevention and Control manual, interview with PSW, IPAC Lead and Administrator. [733564]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to implement the Infection Prevention and Control (IPAC) Standard, issued by the Director with respect to infection prevention and control.

The IPAC Standard for Long-Term Care Homes, April 2022 states: The licensee shall

ensure that there are policies and procedures in place to determine the frequency of surface cleaning and disinfection using a risk stratification approach, and the licensee shall ensure that surfaces are cleaned at the required frequency. The licensee shall ensure that adequate personnel are available on each shift to complete required surface cleaning and disinfection.

Rationale and Summary
Monday through Friday, a few housekeepers were scheduled during the day to clean the entire home. On weekends, a reduced number of housekeepers were scheduled during the day and there were no evening or night housekeeping staff scheduled. Housekeepers shared that when there were reduced housekeeping staff on, including on weekends or if there was a sick call, high touch surfaces were not cleaned as there was not enough time.

The Environmental Manager said that they were aware that high touch surfaces were not being cleaned on a daily basis because there was not enough staff. They said that a reduced number of housekeeping staff were scheduled on weekends.

The IPAC Housekeeping Standards of Practice policy, with a last reviewed date of April 2020, did not include any direction related to cleaning or disinfecting of high touch surfaces and did not indicate what products should be used including the use of a low-level disinfectant. The Administrator shared that they were currently working on the environmental policies in the IPAC manual.

There was risk that infection could spread when, in the absence of appropriate policies and procedures, as well as insufficient housekeeping staffing levels, high touch surfaces were not being cleaned or disinfected on a daily basis.

Sources: Observations, housekeeping shift routines, Infection Control -

Housekeeping Department - Standards of Practice policy #ICM-XII-010, and staff interviews with housekeeping staff, the Environmental Manager, and the Administrator. [213]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 3.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
3. The home's Medical Director.

The licensee has failed to ensure that the continuous quality improvement (CQI) committee included the home's Medical Director.

Rationale and Summary
Several CQI meeting minutes noted that the Medical Director was in attendance at one of the CQI meetings but was not in attendance at several other CQI meetings.

The Administrator said that they had a quality improvement committee, but the Medical Director attended the Professional Advisory Committee (PAC) meetings, where the same data and indicators were reviewed. The Administrator stated that the Medical Director did not attend the CQI meetings, with the exception of one of the CQI meetings.

The CQI Committee policy was dated May 1, 2007, and stated the organization will have a Quality Improvement committee but did not indicate who the committee needed to be comprised of. Input from all required persons was not obtained when

developing quality improvement initiatives in the home, when there wasn't a quality improvement committee with the required membership.

Sources: CQI meeting minutes, CQI Program Policy #CQA - 001, CQI Committee Policy #AQA-004, and interview with the Administrator. [213]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 5.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
5. The home's registered dietitian.

The licensee has failed to ensure that the continuous quality improvement (CQI) committee included the home's registered dietitian.

Rationale and Summary
Several CQI meeting minutes did not include attendance by the home's registered dietitian. The Administrator said that they had a quality improvement committee, but the registered dietitian attended the Professional Advisory Committee (PAC) meetings, where the same data and indicators were reviewed, but did not attend CQI meetings.

The CQI Committee policy was dated May 1, 2007, and stated the organization will have a Quality Improvement committee, but did not indicate who the committee needed to be comprised of. Input from all required persons was not obtained when developing quality improvement initiatives in the home, when there wasn't a quality

improvement committee with the required membership.

Sources: CQI meeting minutes, CQI Program Policy #CQA - 001, CQI Committee Policy #AQA-004, and interview with the Administrator. [213]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 6.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
6. The home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider.

The licensee has failed to ensure that the continuous quality improvement (CQI) committee included the home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider.

Rationale and Summary
Several CQI meeting minutes did not include attendance by the home's pharmacy service provider. The pharmacist was in attendance at one of the CQI meeting. The Administrator said that they have a quality improvement committee, but the pharmacy provider/pharmacist attended the Professional Advisory Committee (PAC) meetings, where the same data and indicators were reviewed, but did not attend CQI meetings, except the one CQI meeting when they were in attendance.

The CQI Committee policy was dated May 1, 2007, and stated the organization will

have a Quality Improvement committee, but did not indicate who the committee needed to be comprised of. Input from all required persons was not obtained when developing quality improvement initiatives in the home, when there wasn't a quality improvement committee with the required membership.

Sources: CQI meeting minutes, CQI Program Policy #CQA - 001, CQI Committee Policy #AQA-004, and interview with the Administrator. [213]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (1)
Continuous quality improvement initiative report
s. 168 (1) Every licensee of a long-term care home shall prepare a report on the continuous quality improvement initiative for the home for each fiscal year no later than three months after the end of the fiscal year and, subject to section 271, shall publish a copy of each report on its website.

The licensee has failed to ensure a report was prepared on the continuous quality improvement (CQI) initiative for the home for each fiscal year no later than three months after the end of the fiscal year and published a copy of the report on its website.

Rationale and Summary
The home's website included a CQI Interim Report dated July 11, with no year indicated. There was no annual Quality Improvement report posted on the home's website. The Administrator said that they created a CQI Interim report, and had created ongoing QI initiatives, but did not create the annual report required in

Ontario Regulation 246/22 s. 168 (1) and (2) in 2023.

The CQI Program Policy was dated June 2011, and stated: In keeping with Section 84 of the new Long Term Care Homes Act, (2007) and regulation 79, section 228. The policy did not include any direction or mention of the requirement to create a report or publish it on the home's website.

There was risk that all required improvements were not addressed or followed up on when the home did not create the required CQI Initiative report.

Sources: Maple Manor website, CQI Interim report, CQI Program Policy #CQA - 001, and interview with the Administrator. [213]

WRITTEN NOTIFICATION: Orientation

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (b)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(b) modes of infection transmission.

The licensee has failed to ensure that the training for staff in infection prevention and control (IPAC), required under paragraph 9 of subsection 82 (2) of the Act, included modes of infection transmission, for a Personal Support Worker.

The Fixing Long Term Care Act, 2021, s. 82 (2) states: Every licensee shall ensure that no staff of the home perform their responsibilities before receiving training in IPAC.

Rationale and Summary

The Surge Learning online training records for a PSW, did not include modes of infection transmission. The Administrator and Director of Care (DOC) said that the PSW was mistakenly entered into Surge as a registered staff member, but that the same training was required for all staff related to IPAC, and they were unsure as to why those topics were not assigned to that PSW for completion. The PSW did complete the required IPAC training as part of their annual training in 2024, but it was not completed prior to performing their duties as a PSW.

There was risk that the staff member was not aware of required IPAC procedures when performing their duties.

Sources: Surge learning online training records for a PSW in 2023 and 2024, and interviews with PSW, Administrator and DOC. [213]

WRITTEN NOTIFICATION: Orientation

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 259 (2) (c)

Orientation

s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,

(c) signs and symptoms of infectious diseases.

The licensee has failed to ensure that the training for staff in infection prevention and control (IPAC), required under paragraph 9 of subsection 82 (2) of the Act, included signs and symptoms of infectious diseases, for a Personal Support Worker (PSW).

The Fixing Long Term Care Act, 2021, s. 82 (2) states: Every licensee shall ensure

that no staff of the home perform their responsibilities before receiving training in IPAC.

Rationale and Summary
The 2023 Surge Learning online training records for a PSW did not include signs and symptoms of infectious diseases. The Administrator and Director of Care (DOC) said that the PSW was mistakenly entered into Surge as a registered staff member, but that the same training was required for all staff related to IPAC, and they were unsure as to why those topics were not assigned to that PSW for completion. The PSW did complete the required IPAC training as part of their annual training, but it was not completed prior to performing their duties as a PSW.

There was risk that the staff member was not aware of required IPAC procedures when performing their duties.

Sources: Surge learning online training records for the PSW, and interviews with PSW, Administrator and DOC. [213]

WRITTEN NOTIFICATION: Orientation

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (d)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(d) respiratory etiquette.

The licensee has failed to ensure that the training for staff in infection prevention and control (IPAC), required under paragraph 9 of subsection 82 (2) of the Act included respiratory etiquette, for a Personal Support Worker (PSW).

The Fixing Long Term Care Act, 2021, s. 82 (2) states: Every licensee shall ensure that no staff of the home perform their responsibilities before receiving training in IPAC.

Rationale and Summary
The Surge Learning online training records for a PSW, did not include respiratory etiquette. The Administrator and Director of Care (DOC) said that the PSW was mistakenly entered into Surge as a registered staff member, but that the same training was required for all staff related to IPAC, and they were unsure as to why those topics were not assigned to that PSW for completion. The PSW did complete the required IPAC training as part of their annual training, but it was not completed prior to performing their duties as a PSW.

There was risk that the staff member was not aware of required IPAC procedures when performing their duties.

Sources: Surge learning online training records for PSW, and interviews with PSW, Administrator and DOC. [213]

WRITTEN NOTIFICATION: Orientation

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (e)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control, required under paragraph 9 of subsection 82 (2) of the Act includes,
(e) what to do if experiencing symptoms of infectious disease.

The licensee has failed to ensure that the training for staff in infection prevention

and control (IPAC), required under paragraph 9 of subsection 82 (2) of the Act, included what to do if experiencing symptoms of infectious disease, for a Personal Support Worker (PSW).

The Fixing Long Term Care Act, 2021, s. 82 (2) states: Every licensee shall ensure that no staff of the home perform their responsibilities before receiving training in IPAC.

Rationale and Summary
The Surge Learning online training records for a PSW did not include what to do if experiencing symptoms of infectious disease. The Administrator and Director of Care (DOC) said that the PSW was mistakenly entered into Surge as a registered staff member, but that the same training was required for all staff related to IPAC, and they were unsure as to why those topics were not assigned to that PSW for completion. The PSW did complete the required IPAC training as part of their annual training, but it was not completed prior to performing their duties as a PSW.

There was risk that the staff member was not aware of required IPAC procedures when performing their duties.

Sources: Surge learning online training records for PSW, and interviews with PSW, Administrator and DOC. [213]

WRITTEN NOTIFICATION: Orientation

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (f)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,

(f) cleaning and disinfection practices.

The licensee has failed to ensure that the training for staff in infection prevention and control (IPAC), required under paragraph 9 of subsection 82 (2) of the Act, included cleaning and disinfection practices, for a Personal Support Worker (PSW).

The Fixing Long Term Care Act, 2021, s. 82 (2) states: Every licensee shall ensure that no staff of the home perform their responsibilities before receiving training in IPAC.

Rationale and Summary
The Surge Learning online training records for a PSW did not include cleaning and disinfection practices. The Administrator and Director of Care (DOC) said that the PSW was mistakenly entered into Surge as a registered staff member, but that the same training was required for all staff related to IPAC, and they were unsure as to why those topics were not assigned to that PSW for completion. The PSW did complete the required IPAC training as part of their annual training, but it was not completed prior to performing their duties as a PSW.

There was risk that the staff member was not aware of required IPAC procedures when performing their duties.

Sources: Surge learning online training records for PSW, and interviews with PSW, Administrator and DOC. [213]

WRITTEN NOTIFICATION: Additional training — direct care staff

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (2) 1.
Additional training — direct care staff

s. 261 (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 82 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 82 (7) of the Act.

The licensee has failed to ensure that all registered staff who provided direct care to residents, completed their assigned annual training in Fall Prevention and Management, Pain Management, and Skin and Wound Care Management.

Rationale and Summary
The Director Care (DOC) provided the Surge Training records for registered staff, for the areas of pain management, falls prevention and skin and wound management.

The pain management included two modules and the records showed 18 out of 24 staff or 75% and 16 out of 24 or 67% completed.
The falls prevention records showed 19 out of 22 staff or 86% completed.
The skin and wound modules included only pressure ulcer prevention and pressure injury staging, but no other forms of altered skin integrity and the records showed 18 out of 24 or 75% completed and 17 out of 24 or 71% completed.

The Administrator and DOC said that they did not assess individual staff needs and that all modules were assigned to all registered staff including full time, part time, casual and agency staff, to be completed as mandatory training annually. They said that they planned to make changes to the process for following up on training completed as the deadline had been the end of the year, therefore if and when they followed up with staff who had not completed the mandatory training, the year had elapsed. At the time of the inspection, staff who had not completed the assigned 2023 training had not been followed up yet. They said that most of the registered

staff who had not completed the training in 2023 were agency staff and casual staff.

There was risk that registered staff who had not completed the required training, might not be aware of the requirements of care related to fall prevention, pain management and skin and wound care management, which could impact the care of residents.

Sources: Surge training records for registered staff, and interviews with the Administrator and the DOC. [213]