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

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Original Public Report

Report Issue Date: March 1, 2024	
Inspection Number: 2024-1246-0001	
Inspection Type: Proactive Compliance Inspection	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Riverbend Place, Cambridge	
Lead Inspector Kailee Bercowski (000734)	**Inspector Digital Signature** Kailee Bercowski Digitally signed by Kailee Bercowski Date: 2024.03.04 10:41:30 -05'00'
Additional Inspector(s) Nuzhat Uddin (532)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: February 12 - 16, and 20 - 22, 2024

The following intake was inspected:

- Intake: #00108565 - Proactive Compliance Inspection

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
Residents' and Family Councils
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: Menu planning

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

Non-compliance with: O. Reg. 246/22, s. 77 (1) (b)

Menu planning

s. 77 (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,

(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks;

The licensee has failed to ensure the home's menu cycle included a menu for a therapeutic diet.

Rationale and Summary

The home's dietary manager & registered dietitian (RD) reported the home did not have therapeutic menus. Instead, they used care plan interventions to individualize the regular menu's offerings to meet residents' dietary needs. The interventions would be communicated to dietary staff in residents' respective plans of care.

At the time of inspection, the RD confirmed a resident's plan of care did not include

sufficient information for staff to identify and provide substitutions of inappropriate foods in the regular menu for the resident's therapeutic diet.

When the home's process for individualized therapeutic diets was not implemented, a resident was at risk of unintentionally receiving inappropriate foods for their dietary needs, and an accelerated progression of their associated health concerns.

Sources: A resident's clinical records, as well as interviews with the home's RD and other staff.
[000734]

WRITTEN NOTIFICATION: Menu planning

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (2) (c)
Menu planning
s. 77 (2) The licensee shall ensure that, prior to being in effect, each menu cycle,
(c) is approved for nutritional adequacy by a registered dietitian who is a member of the staff of the home, and who must take into consideration,
(i) subsection (1),
(ii) the residents' preferences, and
(iii) current Dietary Reference Intakes (DRIs) relevant to the resident population. O. Reg. 246/22, s. 390 (1).

The licensee has failed to ensure the 2023 menu cycles were approved for nutritional adequacy by the in-home registered dietitian.

Rationale and Summary
The dietary manager indicated there were four menu cycles in 2023, with the spring and summer menus reviewed together in the spring, and the fall and winter menus

reviewed together in the fall.

The home's RD stated they had not been involved in evaluating the nutritional adequacy of the home's menu cycles in 2023. They indicated the previous dietitian had completed the nutritional adequacy evaluation of the 2023 menu cycles.

The dietary manager reported the prior dietitian had not completed an evaluation of all 2023 menu cycles for nutritional adequacy, and indicated there had been a miscommunication regarding the 2023 menu cycles.

At the time of inspection, the 2023 Fall/Winter texture modified menus in place were missing a choice of entrée protein or dessert at several lunch and dinner meals across the four week cycle.

When an evaluation of nutritional adequacy was not completed for the home's menu cycles, residents were at risk of receiving nutritionally insufficient diets.

Sources: Interviews with the home's dietary manager and RD; 2023 Fall & Winter Menus
[000734]

WRITTEN NOTIFICATION: Menu planning

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (3)
Menu planning
s. 77 (3) The licensee shall ensure that a written record is kept of the evaluation under clause (2) (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that the changes were implemented. O. Reg. 246/22, s. 390 (1).

The licensee has failed to ensure a written record was retained of the evaluation under Ontario Regulation 246/22 s. 77 (2)(b) for the spring and summer menu cycles of 2023.

Rationale and Summary
The dietary manager described two menu cycle approvals happening in 2023, one in the spring and fall.

During the inspection, the dietary manager was unable to provide a written record of the menu cycle evaluation from the spring of 2023 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made, and the date that the changes were implemented.

When a written record was not maintained for the home's menu cycle approval, staff would be unable to complete an analysis and evaluation of the changes made to the base menu, including a review of nutritional adequacy.

Sources: 2023 Food & Dining Committee meeting minutes, as well as interviews with the home's dietary manager and other staff.
[000734]

WRITTEN NOTIFICATION: Menu planning

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)
Menu planning
s. 77 (5) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 246/22, s. 390 (1).

The licensee has failed to ensure planned menu items were offered and available at each snack.

Rationale and Summary
A review of food & dining meeting minutes from August and September 2023 indicated residents had expressed concerns of two choices not being offered at snack service. At a November 2023 meeting, the dietary manager provided an update that gaps had identified and addressed with two choices being offered at the evening snack service.

During the inspection, a dietary aide & two nursing staff members reported only one snack choice was available on the snack cart, or offered to residents during the afternoon snack service.

The dietary manager confirmed the afternoon snack menu for that day included a choice of buttered raisin bread or assorted cookies, and both choices should have been available on the cart and offered to residents.

When residents were not offered the planned snack menu items, they did not have a choice of what to eat at their afternoon snack, and may have declined the snack altogether.

Sources: Inspector observation in February 2024; Afternoon Snack Menu for February 2024; Interviews with a Dietary Aide and other staff.
[000734]

WRITTEN NOTIFICATION: Dining and snack service

NC #005 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 beverages were served at safe and palatable temperatures.

Rationale and Summary
On January 2023, a public health inspection report reminder for safe food handling was issued to the home. The report indicated staff should use ice baths during meal service to submerge potentially hazardous foods, including milk, to ensure they do not remain within the temperature range of 4°C and 60°C, (or 40°F-160°F) for more than two hours.

At two separate meal observations, milk designated for residents' consumption in pre-portioned cups and a bag container were observed without measures of refrigeration for periods of 45 and 54 minutes. When the temperature was taken for the milk during one of the meals, it was noted to be at 11°C (53°F).

Dietary staff present for those meals reported this was the regular process for beverages during meal services, and that the milk containers would be reused at subsequent meal services.

The home's dietary manager said higher risk beverages, including milk, should be put on ice during meal service.

When milk beverages were not maintained at safe and palatable temperatures for

residents during meal service, residents were at increased risk of an unpleasant meal experience, and foodborne illness.

Sources: Public Health Food Safety Inspection Report # INS-026-68599, inspector observations in February 2024, as well as interviews with the home's dietary manager and other staff.
[000734]

WRITTEN NOTIFICATION: Housekeeping

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (ii)
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:
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids

As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee has failed to ensure that procedures were developed and implemented for cleaning and disinfection of devices using at a minimum, a low-level disinfectant in accordance with evidence-based practices.

Rationale and Summary
The Licensee's Cleaning & Disinfection of Specific Non-Critical Reusable Resident

equipment/Items, provided guidelines for staff to clean pieces of equipment used for residents.

During the inspection, staff were observed not following the home's guidelines for cleaning equipment between use with different residents on two separate occasions, with different pieces of equipment.

The home's IPAC lead said that the equipment should have been cleaned between resident use.

Failure to implement cleaning and disinfection procedures for medical devices in accordance with evidence-based practices may contribute towards disease outbreaks or a delay in controlling the duration of outbreaks.

Sources: The Licensee's Cleaning & Disinfection of Specific Non-Critical Reusable Resident equipment/Items, Observations in February 2024, Interview with the home's IPAC lead and other staff.
[532]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #007 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 ensure that any standard or protocol issued by the

Director with respect to IPAC was implemented.

Rationale and Summary

The IPAC Standard for Long-Term Care Homes (LTCHs), dated April 2022, section 10.4 (h), indicates that the licensee shall ensure that the hand hygiene program includes policies and procedures, as a component of the overall IPAC program, as well as support for residents to perform hand hygiene prior to receiving meals.

Resident Hand Hygiene (HH) Policy #IPC2-O10.14 – ON - LTC, reviewed March 31, 2023, stated that residents who were independent were to be encouraged to perform hand hygiene by:

-Washing their hands with soap and under running water via sink in their room or

-Use of alcohol based hand rub (ABHR) was to be encouraged and reminded upon entry to the dining room.

ABHR will be accessible on snack cart for staff to offer to those residents who wish to perform HH.
Residents who cannot independently perform HH were supposed to be offered assistance to perform hand hygiene by:

-Pumping ABHR into resident hands and sanitizing their hands for them

-Wash the hands with soap and water under running water in their room/bathroom and then offer ABHR prior to eating their meal or snack.

-Sanitizing wet wipes with at least 70% alcohol may be used by / for Resident hand hygiene where the local public health / Health Authority supports their use.

During the inspection, residents were observed to not be offered ABHR for HH at two separate meal services. At those times, ABHR receptacles at the entrance to the dining room were observed to be empty, expired, or not posted.

Staff assistance with resident HH was also not observed at a snack service. At that time, no ABHR bottle was present on the snack cart.

The IPAC Lead stated that staff were trained to offer the ABHR and /or soap and water for hand hygiene before and after meals, as well as before and after nourishment. The ABHR was supposed to be accessible on the snack cart for staff to offer to residents to perform HH.

Gaps in residents' hand hygiene practice increased the risk of possible transmission of infectious microorganisms.

Sources: Resident Hand Hygiene (HH) Policy #IPC2-O10.14 – ON - LTC, three separate observations in February 2024, and interviews with a resident, the IPAC Lead, and other staff.
[532]

WRITTEN NOTIFICATION: Drug destruction and disposal

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (3) (b) (i)
Drug destruction and disposal
s. 148 (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care

The licensee has failed to ensure that the drugs were destroyed by a team acting together and composed of, one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care.

Rationale and Summary
A Stericycle bin was noted inside the medication room where Non-Controlled Drugs for Destruction were placed once they were discontinued or expired.

The Licensee's policy regarding destruction of discontinued/expired medications section 24.4.2 stated that prior to the lid being sealed, drugs must be destroyed by creating a slurry. The destruction was to be completed by two staff members appointed by the home's DOC, including one member of the registered nursing staff.

During the inspection, records and staff interviews indicated the drug destruction was not completed with two staff present.

The Director Of Care (DOC) acknowledged that due to staffing changes, the process was not being followed.

Sources: Record review of MediSystem Policies & Procedures Section 22 (Dated December 2023,) observations in February 2024, as well as interviews with the DOC and other staff.
[532]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 168 (2) 6.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
i. the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,
ii. any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions,
iii. the role of the Residents' Council and Family Council, if any, in actions taken under subparagraphs i and ii,
iv. the role of the continuous quality improvement committee in actions taken under subparagraphs i and ii, and
v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure the continuous quality initiative report for the fiscal year of 2022-2023 contained the following elements required by Ontario Regulations 246/22 s. 168 (2) (6):
A written record of,

> i. the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of

the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,

ii. any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions,

iii. the role of the Residents' Council and Family Council, if any, in actions taken under subparagraphs i and ii,

iv. the role of the continuous quality improvement committee in actions taken under subparagraphs i and ii, and

v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

Rationale and Summary

At time of inspection, the home's management indicated that the posted Continuous Quality Improvement report from the 2022-2023 fiscal year did not contain the legislated components listed above.

When a written record was not maintained for the home's continuous quality improvement initiatives of 2022 to 2023, staff would have difficulty evaluating the completion and efficacy of interventions.

Sources: Interviews with the home's Executive Director and Director Of Care; 2022-2023 Continuous Quality Improvement Narrative and Work Plan for Riverbend Place [000734]