Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jun 28, 2021	2021_715672_0016 (A3)	001232-21	Follow up

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership
2020 Fisher Drive Suite 1 Peterborough ON K9J 6X6

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

The Willows Estate Nursing Home
13837 Yonge Street Aurora ON L4G 3G8

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

Amended by JENNIFER BATTEN (672) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

Amendment required to change "Assistant Nutritional Services Manager" to "Nutritional Care Manager" in the finding related to legislative reference r. 73. (1) 6 and the interviews with the Administrator and Registered Dietician were removed from the finding related to legislative reference r. 73. (1) 11.

Issued on this 28th day of June, 2021 (A3)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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Amended by JENNIFER BATTEN (672) - (A3)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 26, 27, 28, 29 and 30, 2021

The following intakes were completed during this inspection:

One intake conducted as a follow up to a previous Compliance Order issued to the home in inspection report #2021_715672_0002, related to the internal infection prevention and control program.

During the course of the inspection, Complaint and Critical Incident System (CIS) inspections were conducted concurrently.

During the Complaint inspection, the following intake(s) were completed:

One intake related to a complaint received regarding allegations of resident neglect, staff to resident abuse, restraining of residents and IPAC practices in the home.

During the CIS inspection, the following intake(s) were completed:

One intake related to allegations of staff to resident abuse and medication administration practices occurring in the home.

One intake related to allegations of staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the

Administrator, Director of Care, Acting Director of Care (ADOC), Nutrition Services Manager (NSM), Registered Dietitian (RD), Environmental Services Manager (ESM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Care Aides (CAs), administration assistants, nursing assistant services manager (NASM), housekeepers, recreation aides, health screeners, maintenance workers, unit clerks, essential caregivers and residents.

The inspector(s) reviewed clinical health records of identified residents, internal policies related to Infection Prevention and Control, Nutritional Care and Prevention of Resident Abuse and Neglect. The Inspector(s) also observed staff to resident and resident to resident care and interactions, along with infection control and medication administration practices in the home.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Nutrition and Hydration
Personal Support Services

During the course of the original inspection, Non-Compliances were issued.

- **4 WN(s)**
- **0 VPC(s)**
- **6 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (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:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

s. 73. (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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (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:
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that meals were served at temperatures which were both safe and palatable to the residents.

During observations of meal services, Inspector noted meals were served to some residents after sitting outside of the rethermal heater(s) for approximately 30 to 90 minutes. Resident #004 requested to speak with Inspector and complained about the breakfast meal being served approximately two hours after it was plated and the food and fluid items being cold. Resident #004 further indicated that when they complained to staff when their meals are cold, there are no offers to reheat any of the items, therefore resident #004 does not finish eating

the meal. Resident #004 and their roommate, resident #003, indicated it was a routine practice in the home for meals to be served when food and fluid items were no longer at safe and palatable temperatures for the residents.

During further observations of meal services, residents #006, #007 and #010 complained to Inspector that their meals had been served to them after the food and fluid items had gone cold and staff did not offer to reheat the items. Resident #006 indicated their breakfast meal had been served at approximately 0850, but they were still waiting for staff assistance at 0945, which was required due to physical limitations. When a staff member arrived to provide the required assistance, they were called away to assist another resident, therefore resident #006 had a further wait. By the time they were able to finish eating, the resident indicated they did not enjoy the meal, therefore did not ingest all of the food and fluid items served to them. During separate interviews, residents #007 and #010 indicated their breakfast meals were served at unpalatable, cool temperatures. The residents further indicated staff members had been too busy to reheat the food and fluid items, therefore they did not complete their meal.

During observations of meal services on a later identified date, resident #023 had their breakfast meal served to their bedroom at 0840 hours, but had not been able to sit down to the meal until 0947 hours, as they had received a shower and personal care from PSW #130 until that time. Inspector observed resident try a bite of the breakfast meal and then push the tray away, stating they did not want it. During an interview, resident #023 indicated the meal was unpalatable due to being served cold. Inspector requested PSW #130 reheat the appropriate food/fluid items and following this, resident #023 ingested the entire meal. Resident further indicated to Inspector that meals were "often served cold" to the residents, which decreased enjoyment and prevented full intake. Resident stated they often "picked at" meals, "couldn't remember the last time" they ate an entire meal due to food and fluid items being served at unpalatable temperatures and believed staff were too busy to reheat meals for the residents.

During observations of the lunch meal, resident #020 had their meal served to them at 1215 hours but did not receive staff assistance with their intake until 1255 hours. When care aide #119 arrived to assist resident #020 with their meal, they held their hand overtop of the plate to assess if it was still warm, and then began assisting the resident with their intake. Inspector asked if the meal was still at a palatable temperature, care aide #119 replied "it's not hot but it's not cold either. I probably should have warmed it up though." Resident #010 also asked to speak

to Inspector again and complained that their lunch meal had been served to them after it had gone cold and staff did not offer to reheat the items, therefore they didn't eat.

During separate interviews, the Assistant Nutritional Services Manager (ANSM) and the Nutritional Services Manager (NSM) indicated the expectation in the home was for food and fluid items to be served to residents at the palatable temperatures indicated within the internal policy entitled "Tray Service". If the temperatures were outside of the guidelines, staff were to implement interventions, such as reheating the meal, and meals were expected to be physically served to the residents within five minutes of having the food temperatures taken.

By not ensuring food and fluid items to be served to residents at palatable temperatures, residents were placed at risk of experiencing poor food and fluid intakes, which could have further negative effects on the resident.

Sources: Observations conducted, review of internal policies related to food temperatures and tray service, interviews with PSWs, ANSM, NSM and Registered Dietitian (RD). [s. 73. (1) 6.]

2. The licensee has failed to ensure that proper techniques including safe positioning, were used to assist residents #005, #007, #009, #010, #011, #012, #013, #014, #015 and #017, who required assistance with eating.

Resident #005 was served their lunch meal while sitting in bed with the head of the bed flat and resident was noted to be leaning heavily to their side and was overheard to be coughing. PSW #110 confirmed the resident was not in a safe position for eating or drinking purposes and raised the head of the bed.

Residents #012 and #013 were served their lunch meals and received assistance from staff with their intake while seated in unsafe positions. During an interview, PSW #107 indicated residents #012 and #013 were supposed to be in the observed positions during food and fluid intake. Record review of the residents' current written plan of care indicated both residents required fully upright positions during food and fluid intake for identified reasons.

Residents #007, #010 and #011 were served their lunch meals while in bed, with the head of the bed left flat and the residents were noted to be struggling to sit

upright. Resident #010 was noted to have not eaten much of the meal and during an interview they indicated they didn't have the strength to sit up without support for an entire meal, so they had "given up" on the meal. During separate interviews, PSWs #107, #109 and #110 indicated the residents were not in a safe position for eating/drinking purposes and raised the head of the beds to assist the residents and provide some seating support.

On a later identified date, residents #009 and #010 were served their lunch meals while in bed, with the head of the bed left flat and the residents were noted to be struggling to sit upright. During an interview, PSW #109 indicated the residents were not in a safe position for eating/drinking purposes and raised the head of the beds to assist the residents and provide some seating support. Record review of resident #009's current written plan of care indicated they were at nutritional risk due to health conditions.

Residents #012 and #015 were served their lunch meals and received assistance from staff with their intake while seated in unsafe positions. During an interview, RN #118 verified residents #012 and #015 were not in a safe position for eating/drinking purposes and requested the PSWs providing assistance with their meals sit the residents upright for the rest of their food/fluid intake.

On another identified date, residents #014 and #017 were served their lunch meals while in bed, with the head of the bed left flat and the residents were noted to be struggling to sit upright.

During meal services observations, Inspector noted several instances of staff members standing while assisting residents with their food and/or fluid intake. During separate interviews, PSWs #109 and #110, RN #118, the ADOC and RD indicated the expectation in the home was for staff to be in a seated position while assisting residents with their meals in order to promote correct resident positioning and decrease the risk of choking.

By not ensuring residents were in safe positions during food and fluid intake, residents were placed at risk of experiencing episodes of choking and/or aspiration.

Sources: Observations conducted, record review of resident #005, #007, #009, #010, #011, #012, #013, #014, #015 and #017's current written plans of care, interviews with PSWs, RN #118, the ADOC and Registered Dietitian (RD). [s. 73.

(1) 10.]

3. The licensee has failed to ensure there was appropriate furnishings and equipment for residents during meal and snack services.

During observations of meal services, Inspector noted meals were served to some residents on top of their personal mobility aids, dresser tops and on the foot of beds. Inspector also observed some residents struggling to eat while in bed and was informed by both residents and staff that there were not enough overbed tables or chairs in the home to be in resident rooms and used to assist during meals.

During an observation, Inspector noted that resident #007's meal was served on top of their mobility device, which they were using as a table top, while sitting on the edge of the bed. Resident #007 indicated it was too difficult to eat with their back against the raised head of the bed since the meal was served on top of their mobility device, so they needed to continue turning to their side to access the meal tray, unless they rested the tray on their lap or bedspread, but were worried about spilling if they did so. Resident further indicated that sitting off the side of the bed during meals was painful for them due to a specified reason, as the position did not provide any back or trunk support.

During separate interviews, PSWs #109 and #129 indicated there were not enough overbed tables for each resident who was served meals in their room to have one, therefore staff "had to be creative" and routinely served meals on top of walkers, wheelchair seats, the foot of the bed, etc. PSWs #109 and #129 further indicated there were residents in the home who struggled to eat while in bed for different reasons, such as pain control, but there were not enough chairs available for them to be used in resident rooms. Lastly, PSWs #109 and #129 indicated the concern related to the lack of appropriate furnishings and equipment for residents during meal and snack services had been brought forward to the charge nurses and management team "many, many times" but no supplies had been provided.

During separate interviews, the RD indicated they were aware there was a concern in the home related to a possible lack of appropriate furnishings and equipment for residents to use during meal and snack services, but the Administrator was in charge of the budget for furnishings in the home. The RD further indicated a lack of appropriate furnishings and equipment for residents to use during meal and snack services could pose an increased risk of choking and

aspiration to the residents by promoting poor body mechanics and positioning. The Administrator indicated they were aware of the lack of appropriate furnishings and equipment for residents to use during meal and snack services and was hoping to be able to order new supplies for the residents.

By not ensuring residents had the appropriate furnishings and equipment to be used during meal and snack services, they were placed at possible risk of choking and aspiration due to poor body mechanics and positioning. Residents were also placed at risk of decreased intake of food and fluid items related to possibly spilling the items or through a lack of enjoyment of the meal experience from discomfort.

Sources: Observations conducted; interviews with resident #007, PSWs #109 and #129, the Administrator and RD. [s. 73. (1) 11.]

4. The licensee failed to ensure that no resident who required assistance with eating or drinking were served a meal until someone was available to provide the assistance required by the resident.

During observations of lunch meal services, Inspector noted meal trays were served to multiple residents at approximately 1200 hours, and at 1300 hours, they were still waiting for assistance with feeding. On an identified date during the breakfast meal service, meal trays were served to multiple residents at approximately 0800 hours, and at 0930 hours, some residents were still waiting for assistance with feeding. The meal containers felt cool to the touch when staff began assisting residents, with no attempts or offers made to reheat the food items.

PSWs #109, #110, #119, #129 and #130 all indicated it was a routine practice in the home for meals to be delivered to residents once they were plated, and a staff member would assist the resident with their intake once they became available. The staff members further indicated meals were served to residents prior to a staff member being available to provide the required assistance due to the home not having enough staff members present during meals, especially since the home moved to two sittings for each meal, which led to meals taking two to three hours each.

The Administrator, Assistant Director of Care (ADOC), Nutritional Services Manager (NSM) and Registered Dietitian (RD) confirmed the expectation in the

home was for meals to not be served to any resident who required assistance until a staff member was available to assist.

The failure to provide assistance to residents who needed to be fed their meals posed a risk of poor intake, decreased enjoyment of the meal and contamination of the food or fluid items, as meals were left sitting in excess of one hour.

Sources: Observations conducted; record review of resident #002, #004, #005, #006, #007, #009, #010, #011, #012, #013, #014, #015, #017, #020 and #023's current written plans of care; interviews with PSWs, the Administrator, Assistant Director of Care (ADOC), Nutritional Services Manager (NSM) and Registered Dietitian (RD). [s. 73. (2) (b)]

Additional Required Actions:

CO # - 001, 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A3)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 005,001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a designated staff member to co-ordinate the infection prevention and control program with education and experience in infection prevention and control practices which included infectious disease, cleaning and disinfection, data collection and trend analysis, reporting protocols and outbreak management.

A Compliance Order was issued to the home in inspection report #2021_715672_0002, on January 19, 2021, related to the internal infection prevention and control program, with a compliance due date of January 27, 2021. While conducting an IPAC assessment, Inspector inquired into the licensee's designated IPAC lead and was informed the new DOC was assisting with overseeing the IPAC program in the home, with plans of assigning the BSO RPN to the role of IPAC lead. As the DOC was newly hired, the nursing assistant service manager had previously overseen the IPAC program in the home.

During separate interviews, the Administrator indicated the nursing assistant service manager's educational level was as a Personal Support Worker (PSW) and they were not aware of them having previous education or experience in infection prevention and control practices, which was why the new DOC would oversee the program until the BSO RPN could take on that responsibility. The nursing assistant service manager indicated they had been overseeing the licensee's IPAC program for several months but had not received previous education related to IPAC and did not have previous experience co-ordinating an

infection prevention and control program. The DOC and BSO RPN also indicated neither had previous experience or education related to infection prevention and control measures, cleaning and disinfection, data collection and trend analysis, reporting protocols and outbreak management.

By not ensuring there was a designated staff member to co-ordinate the infection prevention and control program with education and experience in infection prevention and control practices which included infectious disease, cleaning and disinfection, data collection and trend analysis, reporting protocols and outbreak management, residents and staff were placed at possible risk of being in an environment where IPAC measures were not properly monitored or implemented. This could lead to improperly managed outbreaks in the home.

Sources: Interviews with the Administrator, nursing assistant service manager, BSO RPN and DOC. [s. 229. (3)]

2. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

A Compliance Order was issued to the home in inspection report #2021_715672_0002, on January 19, 2021, related to the internal infection prevention and control program, with a compliance due date of January 27, 2021.

The following observations were made during the inspection:

- Residents were not offered or assisted with completing hand hygiene before or after meals or snacks. Staff were also observed to not complete hand hygiene before or after assisting residents with physical contact and personal care.

- The home had an identified number of residents who required contact precautions during care, which included the use of gowns, gloves, masks, eye protection and disinfectant wipes. The residents had Personal Protective Equipment (PPE) caddies posted outside of their bedrooms. During observations, there were instances when each of the caddies were missing one or more of the required PPE items for staff to be able to don prior to providing the resident with assistance.

- Staff were observed assisting/interacting with a resident who required contact/droplet precautions without wearing the required PPE items and/or

cleaning/changing their mask or eye protection.

- Inspector observed one of the shower chairs appeared to be soiled. During an interview, staff #128 indicated the expectation in the home was for staff to clean the shower/bath chairs between usage. Once the chair(s) were clean, staff were supposed to place an orange pylon on top of the chair to indicate to others the chair was ready to be used again. During the observation, the pylon was noted to be sitting in the corner of the shower room and staff #128 indicated they had forgotten to clean the chair after usage that morning. On a later specified date, Inspector again observed the same shower chair and it appeared to be soiled.

– Take out coffee cups and water bottles were observed on linen carts and/or the nursing stations in the RHAs. During separate interviews, staff verified the drinks belonged to staff members and were not supposed to be on the linen carts in the RHAs.

- Registered staff were observed administering medications to residents without completing hand hygiene between every resident.

- Multiple residents were observed on the RHAs without maintaining physical distancing and/or wearing masks.

- Staff were observed using equipment such as vital sign machines which included finger monitors on multiple residents without cleaning or disinfecting any of the items between use.

- The licensee directed essential caregivers upon entrance to the home to put on PPE items, including gowns, at the front entrance, then walk through the RHAs to the resident room they were visiting. Once the visit ended, the essential caregivers were instructed to walk through the RHAs and return to the entrance of the home in the same PPE items, then remove them upon exiting the home.

The ADOC, DOC and Administrator confirmed education had been provided to staff and essential caregivers related to the appropriate usage of PPE and hand hygiene principles. The expectation in the home was always for the best practice guidelines related to infection prevention and control to be followed by every individual in the home. The Administrator indicated they were in the process of providing ongoing education and training to the staff related to hand hygiene and the usage of PPE and was completing on the spot redirection when incidents of

noncompliance were observed.

During a telephone interview, the Public Health agent indicated it was not recommended for staff members to have any food or drinks on the RHAs, or for any individual to be present in common areas, such as hallways and elevators, with possibly contaminated PPE items on, after visiting resident bedrooms. The Public Health agent further indicated it would be best practice for the individual to remove and dispose of PPE items such as gowns and gloves at the entrance to the resident room in which they visited, disinfect the eye protection worn during the visit and to replace the mask. The visitor should then walk directly to the exit to the home with a mask and eye protection in place and remove those items upon exiting the home.

The observations and interviews demonstrated there were inconsistent IPAC practices from the staff of the home. The risk associated with the staff not adhering to the home's IPAC program could be possible transmission of infectious agents during the ongoing COVID-19 pandemic.

Sources: Observations conducted; interviews with essential caregiver for resident #003, PSWs, RPNs, RNs, Public Health agent, the ADOC, DOC and Administrator. [s. 229. (4)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

(A2)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés: CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that personal items were labelled, as required.

Observations conducted revealed there were multiple personal items in shared resident bathrooms and the shower rooms, such as used rolls of deodorant and hairbrushes, which were not labelled with the resident's name. Several observations in shared resident bathrooms and the shower rooms indicated there were unlabelled personal items being used for the residents, but staff members could not indicate who the items belonged to and/or were used for residents if the staff had forgotten to bring the resident's own personal item to the shower room. Inspector observed an unlabelled razor on a shelf in the shower room and PSW #106 indicated it was used on both male and female residents, to shave facial and peri areas.

During separate interviews, the DOC verified the expectation in the home was for all personal items to be labelled with the resident’s name. The Administrator indicated they had also noticed multiple unlabelled personal items in the home and were working on having staff member(s) assigned to assist with going through the home to ensure that all personal items were either labelled or disposed of. By not ensuring all personal items were labelled, residents were placed at risk of using another resident’s personal item, which could be unsanitary.

Sources: Observations conducted; interviews with PSWs, RPNs, the DOC and the Administrator. [s. 37. (1) (a)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 004

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (6) The licensee shall ensure that a full breakfast is available to residents up to at least 8:30 a.m. and that the evening meal is not served before 5:00 p.m. O. Reg. 79/10, s. 71 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that the dinner meal was not served before 1700 hours.

During observations of meal services, Inspector noted residents assisted to the dining area(s) at approximately 1600 hours and the dinner meal started to be served to residents between 1620 and 1630 hours.

During separate interviews, the Nutritional Services Manager (NSM) and the Registered Dietitian (RD) indicated the dinner meal was scheduled to start in the home at 1630 hours. This was due to the home moving to two sittings for each meal, with each sitting lasting approximately one hour each, and the scheduling of the dietary staff. The NSM and RD indicated the meal had to be started by at least 1630 daily, in order for the dietary staff to be able to complete all the assigned tasks prior to the end of their shifts.

By not ensuring the dinner meal was served after 1700 hours, residents were placed at risk of feeling hungry throughout the evening and night. Residents were also placed at risk of not eating a full meal at 1630 hours due to possible compression of meals and snack services, as the breakfast meal was observed to finish at approximately 1000 hours, the morning nourishment cart was served at 1015 hours, the lunch meal was observed to finish at approximately 1315 hours, the afternoon nourishment was served at 1400 hours and then the dinner meal was served at 1630 hours.

Sources: Observations conducted and interviews with the NSM and RD. [s. 71. (6)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

(A3)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 006

Issued on this 28th day of June, 2021 (A3)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JENNIFER BATTEN (672) - (A3)
Inspection No. / No de l'inspection :	2021_715672_0016 (A3)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	001232-21 (A3)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Jun 28, 2021(A3)
Licensee / Titulaire de permis :	0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership 2020 Fisher Drive, Suite 1, Peterborough, ON, K9J-6X6
LTC Home / Foyer de SLD :	The Willows Estate Nursing Home 13837 Yonge Street, Aurora, ON, L4G-3G8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Matthew Riel

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Order / Ordre :

The licensee must be compliant with section s. 73. (2) (b) of O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure the residents who require assistance with eating or drinking will not be served a meal until someone is available to provide the required assistance.

2. Conduct daily audits of meal services for a period of two weeks to ensure meals are not being served to residents who require assistance until someone is available to provide the required assistance. If this practice is noted, provide immediate redirection and re-education. Keep a documented record of the audits completed.

Grounds / Motifs :

(A3)
1. The licensee failed to ensure that no resident who required assistance with eating or drinking were served a meal until someone was available to provide the assistance required by the resident.

During observations of lunch meal services, Inspector noted meal trays were served to multiple residents at approximately 1200 hours, and at 1300 hours, they were still

waiting for assistance with feeding. On an identified date during the breakfast meal service, meal trays were served to multiple residents at approximately 0800 hours, and at 0930 hours, some residents were still waiting for assistance with feeding. The meal containers felt cool to the touch when staff began assisting residents, with no attempts or offers made to reheat the food items.

PSWs #109, #110, #119, #129 and #130 all indicated it was a routine practice in the home for meals to be delivered to residents once they were plated, and a staff member would assist the resident with their intake once they became available. The staff members further indicated meals were served to residents prior to a staff member being available to provide the required assistance due to the home not having enough staff members present during meals, especially since the home moved to two sittings for each meal, which led to meals taking two to three hours each.

The Administrator, Assistant Director of Care (ADOC), Nutritional Services Manager (NSM) and Registered Dietitian (RD) confirmed the expectation in the home was for meals to not be served to any resident who required assistance until a staff member was available to assist.

The failure to provide assistance to residents who needed to be fed their meals posed a risk of poor intake, decreased enjoyment of the meal and contamination of the food or fluid items, as meals were left sitting in excess of one hour.

Sources: Observations conducted; record review of resident #002, #004, #005, #006, #007, #009, #010, #011, #012, #013, #014, #015, #017, #020 and #023's current written plans of care; interviews with PSWs, the Administrator, Assistant Director of Care (ADOC), Nutritional Services Manager (NSM) and Registered Dietitian (RD).

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents as residents were served meals more than one hour prior to receiving the required assistance for food and fluid intake. This practice could lead to food contamination and decreased intake due to unpalatable temperatures.

Scope: The scope of this non-compliance was widespread, as more than three

residents were affected.

Compliance History: One or more areas of non-compliance were issued to the home under different sub-sections of the legislation within the previous 36 months. (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 08, 2021(A1)

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

(A2)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés:

Order # / No d'ordre : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases;
(b) cleaning and disinfection;
(c) data collection and trend analysis;
(d) reporting protocols; and
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2021_715672_0002, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with s. 229 (4) of O. Reg. 79/10.

Specifically, the licensee must:

1. Provide leadership, monitoring, and supervision in all home areas to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices.

2. Complete daily audits of staff adherence specific to hand hygiene and PPE donning/doffing for a period of two weeks. Provide on the spot education and training to staff not adhering with appropriate IPAC measures and track the results of the audits completed to assess if the same staff members are involved in areas of non-compliance. Keep a documented record of the audits completed.

3. Ensure that all PPE caddies are fully stocked and that all caddies have appropriate PPE items in them.

4. Provide cleaning supplies in sufficient quantities as to ensure cleaning is thoroughly completed according to best practices.

Grounds / Motifs :

1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

A Compliance Order was issued to the home in inspection report #2021_715672_0002, on January 19, 2021, related to the internal infection prevention and control program, with a compliance due date of January 27, 2021.

The following observations were made during the inspection:

- Residents were not offered or assisted with completing hand hygiene before or after meals or snacks. Staff were also observed to not complete hand hygiene before or after assisting residents with physical contact and personal care.

- The home had an identified number of residents who required contact precautions during care, which included the use of gowns, gloves, masks, eye protection and disinfectant wipes. The residents had Personal Protective Equipment (PPE) caddies posted outside of their bedrooms. During observations, there were instances when each of the caddies were missing one or more of the required PPE items for staff to be able to don prior to providing the resident with assistance.

- Staff were observed assisting/interacting with a resident who required contact/droplet precautions without wearing the required PPE items and/or cleaning/changing their mask or eye protection.

- Inspector observed one of the shower chairs appeared to be soiled. During an interview, staff #128 indicated the expectation in the home was for staff to clean the shower/bath chairs between usage. Once the chair(s) were clean, staff were supposed to place an orange pylon on top of the chair to indicate to others the chair was ready to be used again. During the observation, the pylon was noted to be sitting in the corner of the shower room and staff #128 indicated they had forgotten to clean the chair after usage that morning. On a later specified date, Inspector again observed the same shower chair and it appeared to be soiled.

– Take out coffee cups and water bottles were observed on linen carts and/or the nursing stations in the RHAs. During separate interviews, staff verified the drinks belonged to staff members and were not supposed to be on the linen carts in the RHAs.

- Registered staff were observed administering medications to residents without

completing hand hygiene between every resident.

- Multiple residents were observed on the RHAs without maintaining physical distancing and/or wearing masks.

- Staff were observed using equipment such as vital sign machines which included finger monitors on multiple residents without cleaning or disinfecting any of the items between use.

- The licensee directed essential caregivers upon entrance to the home to put on PPE items, including gowns, at the front entrance, then walk through the RHAs to the resident room they were visiting. Once the visit ended, the essential caregivers were instructed to walk through the RHAs and return to the entrance of the home in the same PPE items, then remove them upon exiting the home.

The ADOC, DOC and Administrator confirmed education had been provided to staff and essential caregivers related to the appropriate usage of PPE and hand hygiene principles. The expectation in the home was always for the best practice guidelines related to infection prevention and control to be followed by every individual in the home. The Administrator indicated they were in the process of providing ongoing education and training to the staff related to hand hygiene and the usage of PPE and was completing on the spot redirection when incidents of noncompliance were observed.

During a telephone interview, the Public Health agent indicated it was not recommended for staff members to have any food or drinks on the RHAs, or for any individual to be present in common areas, such as hallways and elevators, with possibly contaminated PPE items on, after visiting resident bedrooms. The Public Health agent further indicated it would be best practice for the individual to remove and dispose of PPE items such as gowns and gloves at the entrance to the resident room in which they visited, disinfect the eye protection worn during the visit and to replace the mask. The visitor should then walk directly to the exit to the home with a mask and eye protection in place and remove those items upon exiting the home.

The observations and interviews demonstrated there were inconsistent IPAC practices from the staff of the home. The risk associated with the staff not adhering to the home's IPAC program could be possible transmission of infectious agents during

the ongoing COVID-19 pandemic.

Sources: Observations conducted; interviews with essential caregiver for resident #003, PSWs, RPNs, RNs, Public Health agent, the ADOC, DOC and Administrator.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents because of the potential for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program.

Scope: The scope of this non-compliance was widespread, as the IPAC related concerns were identified during observations throughout the home, and the areas of non-compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: A previous Compliance Order had been issued to the home on January 19, 2021, in inspection #2021_715672_0002, with a compliance due date of January 27, 2021.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 24, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 004

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Order / Ordre :

The licensee must be compliant with with s. 37 (1) of O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure that every resident has their personal items labelled, as required.

2. Conduct weekly audits on each of the resident home areas for a period of one month of shared resident bedrooms, bathrooms and spa/shower rooms to ensure all personal items are labelled with the resident's name. Keep a documented record of the audits completed.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Grounds / Motifs :

1. The licensee has failed to ensure that personal items were labelled, as required.

Observations conducted revealed there were multiple personal items in shared resident bathrooms and the shower rooms, such as used rolls of deodorant and hairbrushes, which were not labelled with the resident's name. Several observations in shared resident bathrooms and the shower rooms indicated there were unlabelled personal items being used for the residents, but staff members could not indicate who the items belonged to and/or were used for residents if the staff had forgotten to bring the resident's own personal item to the shower room. Inspector observed an unlabelled razor on a shelf in the shower room and PSW #106 indicated it was used on both male and female residents, to shave facial and peri areas.

During separate interviews, the DOC verified the expectation in the home was for all personal items to be labelled with the resident’s name. The Administrator indicated they had also noticed multiple unlabelled personal items in the home and were working on having staff member(s) assigned to assist with going through the home to ensure that all personal items were either labelled or disposed of. By not ensuring all personal items were labelled, residents were placed at risk of using another resident’s personal item, which could be unsanitary.

Sources: Observations conducted; interviews with PSWs, RPNs, the DOC and the Administrator.

An order was made by taking the following factors into account:

Severity: There was minimal risk of harm to the residents as residents were at risk of using personal items that had been used by other residents. This practice could lead to infection control concerns including the possible spread of contagions.

Scope: The scope of this non-compliance was widespread, as more than three residents were affected.

Compliance History: One or more areas of non-compliance were issued to the home under different sub-sections of the legislation within the previous 36 months.
(672)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jul 08, 2021(A1)

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 005

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (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:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee must be compliant with section s. 73. (1) 6, s. 73. (1) 10 and s. 73. (1) 11 of O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure residents are safely positioned during all food and fluid intake. If unsafe positioning is noted, provide immediate redirection and reeducation.

2. Conduct daily audits of meal services for a period of two weeks to ensure food and fluid items are at palatable temperatures when served to the residents. If unpalatable temperatures are noted, provide immediate interventions. Keep a documented record of the audits completed, which include the time the meal was served to the resident, temperatures of the food and fluid items along with the time the temperatures were taken and any required interventions.

3. Ensure there is appropriate furnishings and equipment for residents to use during meal and snack services. Conduct daily audits for a period of one week to ensure that all residents eating in their room have the appropriate furnishings to support an enjoyable dining experience. Keep a documented record of the audits completed.

Grounds / Motifs :

(A3)
1. The licensee has failed to ensure that meals were served at temperatures which were both safe and palatable to the residents.

During observations of meal services, Inspector noted meals were served to some residents after sitting outside of the rethermal heater(s) for approximately 30 to 90 minutes. Resident #004 requested to speak with Inspector and complained about the breakfast meal being served approximately two hours after it was plated and the food and fluid items being cold. Resident #004 further indicated that when they complained to staff when their meals are cold, there are no offers to reheat any of the items, therefore resident #004 does not finish eating the meal. Resident #004 and their roommate, resident #003, indicated it was a routine practice in the home for meals to be served when food and fluid items were no longer at safe and palatable temperatures for the residents.

During further observations of meal services, residents #006, #007 and #010 complained to Inspector that their meals had been served to them after the food and fluid items had gone cold and staff did not offer to reheat the items. Resident #006 indicated their breakfast meal had been served at approximately 0850, but they were still waiting for staff assistance at 0945, which was required due to physical limitations. When a staff member arrived to provide the required assistance, they were called away to assist another resident, therefore resident #006 had a further wait. By the time they were able to finish eating, the resident indicated they did not enjoy the meal, therefore did not ingest all of the food and fluid items served to them. During separate interviews, residents #007 and #010 indicated their breakfast meals were served at unpalatable, cool temperatures. The residents further indicated staff members had been too busy to reheat the food and fluid items, therefore they did not complete their meal.

During observations of meal services on a later identified date, resident #023 had their breakfast meal served to their bedroom at 0840 hours, but had not been able to sit down to the meal until 0947 hours, as they had received a shower and personal care from PSW #130 until that time. Inspector observed resident try a bite of the breakfast meal and then push the tray away, stating they did not want it. During an interview, resident #023 indicated the meal was unpalatable due to being served cold. Inspector requested PSW #130 reheat the appropriate food/fluid items and following this, resident #023 ingested the entire meal. Resident further indicated to Inspector that meals were "often served cold" to the residents, which decreased enjoyment and prevented full intake. Resident stated they often "picked at" meals, "couldn't remember the last time" they ate an entire meal due to food and fluid items being served at unpalatable temperatures and believed staff were too busy to reheat meals for the residents.

During observations of the lunch meal, resident #020 had their meal served to them at 1215 hours but did not receive staff assistance with their intake until 1255 hours. When care aide #119 arrived to assist resident #020 with their meal, they held their hand overtop of the plate to assess if it was still warm, and then began assisting the resident with their intake. Inspector asked if the meal was still at a palatable temperature, care aide #119 replied "it's not hot but it's not cold either. I probably should have warmed it up though." Resident #010 also asked to speak to Inspector again and complained that their lunch meal had been served to them after it had

gone cold and staff did not offer to reheat the items, therefore they didn't eat.

During separate interviews, the Assistant Nutritional Services Manager (ANSM) and the Nutritional Services Manager (NSM) indicated the expectation in the home was for food and fluid items to be served to residents at the palatable temperatures indicated within the internal policy entitled "Tray Service". If the temperatures were outside of the guidelines, staff were to implement interventions, such as reheating the meal, and meals were expected to be physically served to the residents within five minutes of having the food temperatures taken.

By not ensuring food and fluid items to be served to residents at palatable temperatures, residents were placed at risk of experiencing poor food and fluid intakes, which could have further negative effects on the resident.

Sources: Observations conducted, review of internal policies related to food temperatures and tray service, interviews with PSWs, ANSM, NSM and Registered Dietitian (RD).

An order was made by taking the following factors into account:

Severity: There was actual risk of harm, as residents were served meals at unpalatable temperatures, which could lead to decreased food and fluid intake, decreased enjoyment of the meal and food contamination.

Scope: The scope of this non-compliance was widespread, as more than three residents were affected.

Compliance History: One or more areas of non-compliance were issued to the home under different sub-sections of the legislation within the previous 36 months. (672)

2. The licensee has failed to ensure that proper techniques including safe positioning, were used to assist residents #005, #007, #009, #010, #011, #012, #013, #014, #015 and #017, who required assistance with eating.

Resident #005 was served their lunch meal while sitting in bed with the head of the bed flat and resident was noted to be leaning heavily to their side and was overheard to be coughing. PSW #110 confirmed the resident was not in a safe position for eating or drinking purposes and raised the head of the bed.

Residents #012 and #013 were served their lunch meals and received assistance from staff with their intake while seated in unsafe positions. During an interview, PSW #107 indicated residents #012 and #013 were supposed to be in the observed positions during food and fluid intake. Record review of the residents' current written plan of care indicated both residents required fully upright positions during food and fluid intake for identified reasons.

Residents #007, #010 and #011 were served their lunch meals while in bed, with the head of the bed left flat and the residents were noted to be struggling to sit upright. Resident #010 was noted to have not eaten much of the meal and during an interview they indicated they didn't have the strength to sit up without support for an entire meal, so they had "given up" on the meal. During separate interviews, PSWs #107, #109 and #110 indicated the residents were not in a safe position for eating/drinking purposes and raised the head of the beds to assist the residents and provide some seating support.

On a later identified date, residents #009 and #010 were served their lunch meals while in bed, with the head of the bed left flat and the residents were noted to be struggling to sit upright. During an interview, PSW #109 indicated the residents were not in a safe position for eating/drinking purposes and raised the head of the beds to assist the residents and provide some seating support. Record review of resident #009's current written plan of care indicated they were at nutritional risk due to health conditions.

Residents #012 and #015 were served their lunch meals and received assistance from staff with their intake while seated in unsafe positions. During an interview, RN #118 verified residents #012 and #015 were not in a safe position for eating/drinking purposes and requested the PSWs providing assistance with their meals sit the residents upright for the rest of their food/fluid intake.

On another identified date, residents #014 and #017 were served their lunch meals while in bed, with the head of the bed left flat and the residents were noted to be struggling to sit upright.

During meal services observations, Inspector noted several instances of staff members standing while assisting residents with their food and/or fluid intake. During

separate interviews, PSWs #109 and #110, RN #118, the ADOC and RD indicated the expectation in the home was for staff to be in a seated position while assisting residents with their meals in order to promote correct resident positioning and decrease the risk of choking.

By not ensuring residents were in safe positions during food and fluid intake, residents were placed at risk of experiencing episodes of choking and/or aspiration.

Sources: Observations conducted, record review of resident #005, #007, #009, #010, #011, #012, #013, #014, #015 and #017's current written plans of care, interviews with PSWs, RN #118, the ADOC and Registered Dietitian (RD).

An order was made by taking the following factors into account:

Severity: There was actual risk of harm, as residents were assisted with food and fluid intake while in unsafe positions. This practice could lead to a resident choking or aspirating on food and/or fluid items.

Scope: The scope of this non-compliance was widespread, as more than three residents were affected.

Compliance History: One or more areas of non-compliance were issued to the home under different sub-sections of the legislation within the previous 36 months. (672)

(A3)
3. The licensee has failed to ensure there was appropriate furnishings and equipment for residents during meal and snack services.

During observations of meal services, Inspector noted meals were served to some residents on top of their personal mobility aids, dresser tops and on the foot of beds. Inspector also observed some residents struggling to eat while in bed and was informed by both residents and staff that there were not enough overbed tables or chairs in the home to be in resident rooms and used to assist during meals.

During an observation, Inspector noted that resident #007's meal was served on top of their mobility device, which they were using as a table top, while sitting on the edge of the bed. Resident #007 indicated it was too difficult to eat with their back against the raised head of the bed since the meal was served on top of their mobility

device, so they needed to continue turning to their side to access the meal tray, unless they rested the tray on their lap or bedspread, but were worried about spilling if they did so. Resident further indicated that sitting off the side of the bed during meals was painful for them due to a specified reason, as the position did not provide any back or trunk support.

During separate interviews, PSWs #109 and #129 indicated there were not enough overbed tables for each resident who was served meals in their room to have one, therefore staff "had to be creative" and routinely served meals on top of walkers, wheelchair seats, the foot of the bed, etc. PSWs #109 and #129 further indicated there were residents in the home who struggled to eat while in bed for different reasons, such as pain control, but there were not enough chairs available for them to be used in resident rooms. Lastly, PSWs #109 and #129 indicated the concern related to the lack of appropriate furnishings and equipment for residents during meal and snack services had been brought forward to the charge nurses and management team "many, many times" but no supplies had been provided.

During separate interviews, the RD indicated they were aware there was a concern in the home related to a possible lack of appropriate furnishings and equipment for residents to use during meal and snack services, but the Administrator was in charge of the budget for furnishings in the home. The RD further indicated a lack of appropriate furnishings and equipment for residents to use during meal and snack services could pose an increased risk of choking and aspiration to the residents by promoting poor body mechanics and positioning. The Administrator indicated they were aware of the lack of appropriate furnishings and equipment for residents to use during meal and snack services and was hoping to be able to order new supplies for the residents.

By not ensuring residents had the appropriate furnishings and equipment to be used during meal and snack services, they were placed at possible risk of choking and aspiration due to poor body mechanics and positioning. Residents were also placed at risk of decreased intake of food and fluid items related to possibly spilling the items or through a lack of enjoyment of the meal experience from discomfort.

Sources: Observations conducted; interviews with resident #007, PSWs #109 and #129, the Administrator and RD.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

An order was made by taking the following factors into account:

Severity: There was actual risk of harm, as residents were placed at possible risk of choking and aspiration due to poor body mechanics and positioning as a result of the lack of appropriate furnishings and equipment for residents to use during meal and snack services.

Scope: The scope of this non-compliance was widespread, as more than three residents were affected.

Compliance History: One or more areas of non-compliance were issued to the home under different sub-sections of the legislation within the previous 36 months. (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jun 24, 2021

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 006

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (6) The licensee shall ensure that a full breakfast is available to residents up to at least 8:30 a.m. and that the evening meal is not served before 5:00 p.m. O. Reg. 79/10, s. 71 (6).

Order / Ordre :

The licensee must be compliant with with s. 71 (6) of O. Reg. 79/10.

Specifically, the licensee must:

1. Conduct daily audits for two weeks to ensure the dinner meal is not served before 1700 hours. Keep a documented record of the audits completed, which indicates the start time of the meal service.

Grounds / Motifs :

(A3)
1. The licensee has failed to ensure that the dinner meal was not served before 1700 hours.

During observations of meal services, Inspector noted residents assisted to the dining area(s) at approximately 1600 hours and the dinner meal started to be served to residents between 1620 and 1630 hours.

During separate interviews, the Nutritional Services Manager (NSM) and the Registered Dietitian (RD) indicated the dinner meal was scheduled to start in the home at 1630 hours. This was due to the home moving to two sittings for each meal, with each sitting lasting approximately one hour each, and the scheduling of the dietary staff. The NSM and RD indicated the meal had to be started by at least 1630 daily, in order for the dietary staff to be able to complete all the assigned tasks prior to the end of their shifts.

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By not ensuring the dinner meal was served after 1700 hours, residents were placed at risk of feeling hungry throughout the evening and night. Residents were also placed at risk of not eating a full meal at 1630 hours due to possible compression of meals and snack services, as the breakfast meal was observed to finish at approximately 1000 hours, the morning nourishment cart was served at 1015 hours, the lunch meal was observed to finish at approximately 1315 hours, the afternoon nourishment was served at 1400 hours and then the dinner meal was served at 1630 hours.

Sources: Observations conducted and interviews with the NSM and RD.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents as they were placed at risk of feeling hungry throughout the evening and night, along with not eating a full meal due to the meal being too close to the lunch meal and afternoon nourishment.

Scope: The scope of this non-compliance was widespread, as it affected all of the residents in the home.

Compliance History: One or more areas of noncompliance were issued to the home related to different sub-sections of the legislation within the past 36 months. (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 24, 2021

Order(s) of the Inspector

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REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 28th day of June, 2021 (A3)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by JENNIFER BATTEN (672) - (A3)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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Service Area Office / Bureau régional de services : Central East Service Area Office