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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
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Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: January 8, 2024
Original Report Issue Date: December 12, 2023
Inspection Number: 2023-1035-0003 (A1)
Inspection Type: Post-Occupancy Follow up
Licensee: CVH (No. 6) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)
Long Term Care Home and City: Southbridge Cornwall, Cornwall

Amended By	**Inspector who Amended Digital Signature**
Megan MacPhail (551)	Megan K MacPhail Digitally signed by Megan K MacPhail Date: 2024.01.25 11:02:30 -05'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Change the compliance due date of CO #002 from January 25, 2024 to February 15, 2024.

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Lead Inspector Jessica Lapensee (133)	**Additional Inspector(s)** Lisa Cummings (756)
Amended By Megan MacPhail (551)	**Inspector who Amended Digital Signature** Megan K MacPhail Digitally signed by Megan K MacPhail Date: 2024.01.25 11:02:57 -05'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Change the compliance due date of CO #002 from January 25, 2024 to February 15, 2024.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 16, 17, 18, 19, 20, 23, 25, 26, 27, 30, 31, 2023 and November 1, 2023.

The following intake(s) were inspected: Intake: #00089717 - Post Occupancy Inspection.

NOTE: Findings of non-compliance are issued in this report that are associated to intakes in concurrent workspace #2023-1035-0004, report dated December 12, 2023. The findings and intakes are as follows.

- Intake #00089678; Written Notification #003 related to FLTCA, 2021, s. 19 (2) (c), Written Notification #004 related to O Reg. 246/22, s. 24 (1), Written Notification #005 related to O. Reg. 246/22, s. 24 (3) and Compliance Order #003 related to FLTCA, 2021, s. 82 (2) 10.

- Intakes #00092514, #00088141, and #00088268; Written Notification #002 related to O. Reg. 246/22, s. 6 (9) 1.

- Intake #00091647; Written Notification #007 related to O. Reg. 246/22, s. 77 (5) and Written Notification #009 related to O. Reg. 246/22 s. 78 (2) (f).

- Intake #00090017; Written Notification #008 related to O. Reg. 246/22, s. 78 (2) (d).

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

Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control

AMENDED INSPECTION RESULTS

Non-Compliance Remedied

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

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 74 (2) (e) (ii)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(e) a weight monitoring system to measure and record with respect to each resident,
(ii) body mass index and height upon admission and annually thereafter.

The licensee has failed to ensure that the system to measure and record residents height annually was complied with.

Rationale and Summary
One resident's height was measured and recorded on a day in July 2022.

A second resident's height was measured and recorded on a day in September 2022.

The RAI-Coordinator stated a process for measuring and recording residents' heights annually had not been defined. They measured and recorded the two residents' heights on a day in October 2023 and stated that they would be tasked to measure and record residents' heights with the annual MDS assessment.

Sources: Two resident's health care records and interview with the RAI-Coordinator. [551]

Date Remedy Implemented: October 31, 2023

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
Documentation
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

1) The licensee has failed to ensure that a resident's oral care was documented.

Rationale and Summary
The Personal Support Worker (PSW) documentation from an eighteen day period in October 2023 showed that documentation of oral care was included in the day and evening care sections. During this time period, there was documentation missing for sixteen shifts for day care, and documentation missing for five shifts for evening

care.

The Director of Care (DOC) stated that oral care is not documented anywhere else and staff are expected to document the care provided each shift.

Sources: A resident's healthcare record; interview with the DOC.
[756]

2) The licensee has failed to ensure that the provision of bathing care set out in the plan of care was documented for three residents.

Rationale and Summary
Three residents were scheduled to be bathed twice weekly.

A report was generated for a period of 30 days that showed the documented provision of bathing for the three residents.

For the first resident, there was no documentation to indicate that they were bathed on four days during the thirty day period.

For the second resident, the provision of bathing care was documented once during the thirty day period.

For the third resident, the provision of bathing care was not documented at all during the thirty day period.

The DOC stated that the provision of bating care should have been documented each time a resident was bathed.

Sources: Health care records for three residents and interview with the DOC.
[551]

WRITTEN NOTIFICATION: Maintenance

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
Specific duties re cleanliness and repair
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee failed to ensure that the home was maintained in a good state of repair specifically related to doors that lead to the outside that are within stairways.

Rationale and Summary
On a day in October 2023, the inspector observed the doors leading to the outside of the home that were within two stairways in one of the resident home areas and one stairway in the entrance area of the home. It was observed that the doors did not fully extend to the bottom of the door frame. There was a brush style door sweep on the base of each door. The inspector could put their pen under each door with no resistance. An accumulation of dead insects was observed around each door.

The licensee's pest control records from the Pest Control Technician (PCT) were reviewed. The following notes were found:
- In April 2023, in the "sanitation/maintenance concern" section, the PCT wrote " door sweeps need adjustment".

- In June 2023, in the "sanitation/maintenance concern" section, the PCT wrote "door sweeps need attention"
- In July 2023, in the "sanitation/maintenance concern" section, the PCT wrote "door sweeps"
- On the October 2023 report, the PCT confirmed to the inspector that their reference to door sweeps had been in relation to the doors that lead to the outside of the home that are within stairways. They wrote to the inspector "we were getting complaints of small insects in the building. I noticed that a lot of the exit doors, light could be seen through them".

The brush style sweeps were lowered by the Environmental Services Manager however a pen could still go under the doors. The Southbridge Environmental Consultant indicated to the inspector that solid strip style sweeps had been ordered and would be installed on the doors in question.

As such, failure to maintain the doors that lead to the outside within stairways in good repair presents the risk of pests gaining entry to the home.

Sources: Observations of the referenced doors, review of the pest control records from April 2023 to October 2023, interview with the Environmental Services Manager and the Southbridge Environmental Consultant.
[133]

WRITTEN NOTIFICATION: Air Temperature

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is

maintained at a minimum temperature of 22 degrees Celsius.

The licensee has failed to ensure that common areas in the home are maintained at a minimum temperature of 22 degrees Celsius (C).

Rationale and Summary
The following occurred on a day in October 2023:
- A resident home area (RHA) unit hallway thermostat read 20.7C at 1524 hours. The Inspector measured the temperature on the ledge underneath the thermostat and after five minutes the temperature was 21.7C.
- Outside of an identified bedroom on the same RHA, the inspector measured the temperature for five minutes and it was 21.1C. The inspector observed that the air from the nearby ceiling vent could be felt in this location.
- A hallway thermostat near the entrance to a second RHA read 20.1C at 1550 hours. The inspector measured the temperature on the ledge underneath the thermostat and after five minutes the temperature was 21.1C.
- In the second RHA, outside of an identified bedroom, the inspector measured the temperature on the ledge across from the bedroom. After five minutes, the temperature was 21.3C. The Inspector observed that the air from the nearby ceiling vent could be felt in this location.
- In a third RHA, in the lounge next to an identified bedroom, the thermostat read 21.6C at 1604 hours. The Inspector measured the temperature on the ledge underneath the thermostat and after five minutes the temperature was 21.5C.

Regarding the licensees' documented air temperature records for September and October 2023; following a review of the documentation on October 30, 2023 it was noted that temperatures below 22C were documented on 28 of 59 days (47%). The majority of the temperatures documented to be below 22C were in common areas vs resident bedrooms (41 of 47). At the bottom of the temperature monitoring form, it

was written "Temperature between 22C and 26C. If temperature is outside of range, report to Environmental Services Department". The inspector asked the Environmental Services Manager (ESM) if they had been made aware of the documented temperatures below 22 C. The ESM confirmed that they had not been made aware. The ESM explained that resident bedrooms and common areas have two separate heating systems. The ESM indicated that a corporate representative was going to be attending the home to support the ESM on the matter of maintaining the system that serves the common areas as it is not included in the Building Automation System.

As such there was risk that the temperature in the home was not maintained at a comfortable level for the residents.

Sources: Observations of referenced thermostats, observations of inspector's thermometers to measure air temperatures, review of air temperature monitoring records, interview with the Environmental Services Manager.
[133]

WRITTEN NOTIFICATION: Air temperature

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (3)
Air temperature
s. 24 (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The licensee has failed to ensure that the air temperature is measured and documented in writing, at a minimum in at least two resident bedrooms in different

parts of the home and one resident common area on every floor of the home once at least once morning, once every afternoon between 12 p.m. and 5p.m. and once every evening or night.

Rationale and Summary
Air temperature measurement records ("resident room and building temperature log") were reviewed for a period of 59 days. For each day, there should have been 15 documented air temperatures. Of the 885 required entries, 236 were missing. The majority of the missing entries were from the "nursing rounds" section of the daily records, which represents the mandatory "every evening or night" time period.

The inspector showed the Regional Director the documented air temperature records and they acknowledged that many entries were missing. The Director of Care confirmed that the charge nurse was expected to monitor and document the required air temperatures during the night shift, and that this had been discussed with nursing staff recently.

As such there was risk that the temperature in the home was not maintained at a comfortable level for the residents.

Sources: Review of air temperature measurement records, interviews with the Regional Director and Director of Care.
[133]

WRITTEN NOTIFICATION: Weight Changes

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (e) (i)
Nutritional care and hydration programs

s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and

The licensee has failed to ensure that the system to monitor a resident's weight monthly was complied with.

Rationale and Summary
A resident was admitted to the home in 2023. Their admission weight was recorded.

The resident's weight was not recorded the month after their admission. Two months after admission, the resident's weight was recorded and there was a loss of 6.2 per cent.

Failure to monitor the resident's weight monthly meant that potential weight loss the month after their admission was not captured.

Source: A resident's health care record.
[551]

WRITTEN NOTIFICATION: Menu Planning

NC #007 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 that the planned menu items were offered and available at the lunch meal on three days in October 2023 in a resident home area (RHA).

Rationale and Summary
The posted menu stated that bread and/or crackers were offered at lunch and dinner.

The planned menu items for a day in October 2023 included butternut squash and brussel sprouts. Minced squash and pureed brussel sprouts were not available. Bread and/or crackers were not offered.

The planned menu items for a second day in October 2023 included steamed rice, scalloped potatoes, oriental mixed vegetables, peas and strawberry short cake. There was no steamed rice (and minced and pureed rice). There were no minced and pureed scalloped potatoes. There were no minced peas. There were no pureed oriental mix vegetables and pureed strawberry short cake. Bread and/or crackers were not offered.

The Kitchen Production reports for the two days in October 2023, were reviewed, and they listed the following food items as items that should have been prepared: minced butternut squash, pureed brussel sprouts, white rice, minced white rice, pureed white rice, minced scalloped potatoes, pureed scalloped potatoes, pureed asian mixed vegetables, minced green peas, pureed strawberry short cake.

A follow-up observation was conducted at lunch on a third day in October 2023 in the RHA. The planned menu items included boiled potatoes, peppers and onions, apricots and apple crisp, and none of these menu items were available. Peppers and

onions were replaced with corn. Apricots were replaced with strawberries, and apple crisp was replaced with cheesecake. For resident on minced and pureed diets, there was no corn, and as such, there was no choice of other side dish available. Bread and/or crackers were not offered.

The Nutritional Manager (NM) stated that the menu for minced and pureed textured followed the regular texture, and that meals should be prepared according to the Kitchen Production report. The NM stated that soup and therefore crackers were not being offered at this time, and that additional bread/bread product was offered only when part of an entree or side dish.

By not having the planned menu items offered and available, residents did not have a choice of other side dishes at all three meals and a choice of other desserts at lunch and dinner, to meet their specific needs or food preferences.

Sources: Observations, the posted menu, Kitchen Production reports and interview with the NM.
[551]

WRITTEN NOTIFICATION: Food Production

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (2) (d)
Food production
s. 78 (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu;

The licensee has failed to ensure that all menu items, which included a standard portion size, were prepared according to the planned menu.

Rationale and Summary
The portion sizes of the planned menu items were indicated on the Kitchen Production report and on the Dietary Aide's (DA's) computer screen in the servery through the Meal Suite program.

During lunch meal observations on two days in October 2023, and a dinner meal observation on a third day in October 2023, menu items were prepared and served to residents using inconsistent serving utensils. This resulted in smaller portions of some menu items being prepared for and served to residents. For example:

The standard serving size for mashed potatoes and regular texture vegetables is 125 milliliters (mL). DAs were observed using green and ivory scoops, which are less than 125 mL, to serve mashed potatoes.

The standard serving size for rice is 125 mL. A DA was observed using a green scoop, which is less than 125 mL, to serve rice.

The standard serving size for minced and pureed meat and vegetables is a #10 scoop. DAs were observed using blue and green scoops, which are less than a #10 scoop, to serve minced and pureed meat and vegetables.

The NM stated that DAs should serve portions consistent with the portion size that was indicated for the menu item in Meal Suite.

Failure to ensure that menu items were prepared according to the planned portion size could result in a nutritionally inadequate diet for residents.

Sources: Observations, Kitchen Production reports and interview with the NM.

[551]

WRITTEN NOTIFICATION: Food Production

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (2) (f)
Food production
s. 78 (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and

The licensee has failed to ensure that the food production system provided for communication to residents and staff of any menu substitutions on a day in October 2023 at lunch in a resident home area (RHA).

Rationale and Summary
At the lunch meal on a day in October 2023, peppers and onions were substituted with corn, apricots were substituted with strawberries and apple crisp was substituted with cheese cake.

The Menu Substitutions policy (last updated March 2021), directed staff to record the menu substitutions on the daily menu posted in the resident home areas.

The menu substitutions were not recorded on the daily menu, and residents were offered peppers and onions when their orders were taken at the start of the meal service.

By not communicating the menu substitutions, residents were offered a food item that was not available. Any resident who may have looked at the posted menu in advance of the lunch meal was not presented with an accurate choice, to meet their

specific needs or food preferences.

Sources: Observation and Menu Substitutions policy.
[551]

WRITTEN NOTIFICATION: Food Production

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (2) (g)
Food production
s. 78 (2) The food production system must, at a minimum, provide for,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 246/22, s. 78 (2).

The licensee has failed to ensure that the food production system provided for documentation on the production sheet of any menu substitutions.

Rationale and Summary
The daily posted menu stated that the planned menu items for a day in October 2023 included pork chops. The cook had used the pork chops the day prior in error, so they were not available and were substituted with pork pieces in a sauce.

As per the policy titled, Menu Substitutions (NC-05-01-07, last updated March 2021), 3) Menu substitutions were to be recorded on the production sheets.

The NM stated that the cook did not document menu substitutions on the production sheet.

Sources: Menu Substitutions policy and interview with NM.

[551]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.
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:
4. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

The licensee has failed to ensure that the process, to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences, was complied with.

Rationale and Summary
The licensee used Meal Suite, a food service software program, and each resident had a profile that included their diet, special needs and preferences.

At the lunch meal in a resident home area (RHA) on a day in October 2023, the Dietary Aide (DA) did not use Meal Suite to ensure that residents were served according to their diets, special needs and preferences. Entrees were prepared according to a paper list with each residents' name and a check mark next to which entree was chosen. If the resident was not on a regular texture diet, their texture modification was listed beside their name (pureed, minced, minced meat). No special needs such as allergies or intolerances were on the list.

A resident was observed eating in the dining room. They were being assisted, and

they were eating regular texture pork, brussel sprouts and mashed potatoes.

The resident was ordered a puree texture diet.

The NM stated that the DA should have been using their Meal Suite software and cross referencing the entree orders taken by the PSW with the residents' diet orders in Meal Suite.

Failure to follow the process of serving meals according to residents' diet orders resulted in a resident being served the wrong texture diet.

Sources: Observations, a resident's health care record and interview with the NM. [551]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #012 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 comply with the policy to ensure that food was served at a temperature that was both safe and palatable to residents.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that the nutritional care and hydration programs included the development and

implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration, and they must be complied with.

Rationale and Summary
Specifically, the licensee did not comply with the policies titled, Holding and Distribution of Food (NC-07-01-02) and Temperatures of Food at Point of Service (NC-07-01-03) which were included in the licensee's Nutritional Care and Hydration Programs. The policies were last updated March 2021.

The Holding and Distribution of Food policy stated that cooked food will be held at a temperature above 60 degrees Celsius (C) or 40 degrees Fahrenheit (F), and cold foods are to be held at a temperature below four (4) degrees C or 40 degrees F, for no longer than two hours.

The Temperatures of Food at Point of Service policy stated that, we take the holding temperature of foods just before serving to ensure that hot foods are served and held for the duration of meal service outside the danger zone (above 60C/140F and below 4C/40F). The procedure stated that dietary staff will insert the probe of the thermometer into the thickest part of the food. Make sure the probe does not touch bone or the pan. Record the temperature on the Food Temperature Record or another appropriate form provided in Synergy.

At breakfast, on a day in October 2023, the kitchen did not record a temperature for oatmeal and pureed oatmeal. In the five RHAs, no temperature was recorded for any breakfast item.

At lunch, the kitchen did not record a temperature for all menu items, including mashed potatoes, butternut squash (regular and pureed), brussel sprouts (regular

and minced) and the dessert choices. In four of five RHAs, no temperature was recorded for any menu items at lunch and dinner. Temperatures were recorded in one RHA for some food items.

The NM stated that food temperatures should be recorded as per policies.

By not recording food temperatures, the licensee does not have documentation to support that residents were served foods that were safe and palatable.

Sources: Holding and Distribution of Food (NC-07-01-02) and Temperatures of Food at Point of Service (NC-07-01-03) policies, temperature records and interview with the NM.
[551]

WRITTEN NOTIFICATION: Registered Dietitian

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 80 (2)
Registered dietitian
s. 80 (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutritional care duties.

The licensee has failed to ensure that a registered dietitian (RD) who is a member of the staff of the home was on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutritional care duties.

Rationale and Summary
As per the Post-Occupancy Confirmation Checklist completed by the home's

administrator, the home does not have an RD who is a member of staff of the home on site at the home for a minimum of 30 minutes per resident per month.

The home did not have a registered dietitian for a period of twenty days.

The RD, who is contracted through a third party, began work on a day in September 2023. As of the time of the inspection, the RD had never worked on site and worked remotely, off site, only. The RD was unable to complete any referral that required an objective or visual assessment of the resident, such as to complete a dysphagia or swallowing assessment. At the time of the inspection, two consults for one resident who was requesting an upgrade in texture were pending.

The absence of an RD on site meant that the RD could not complete common tasks such as talking directly with residents/families or proactive meal observations, and it affected any resident who required an objective, visual assessment.

Sources: Post-Occupancy Confirmation Checklist and interview with the RD.
[551]

WRITTEN NOTIFICATION: Nutrition Manager

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 81 (5)
Nutrition manager
s. 81 (5) For the purposes of subsection (4), but subject to subsection (6), the minimum number of hours per week shall be calculated as follows:
M = A × 8 ÷ 25
where,
"M" is the minimum number of hours per week, and

"A" is, at the option of the licensee, either,
(a) the licensed bed capacity of the home for the week, excluding beds not available for occupancy pursuant to a Minister's directive, Ministry policy or otherwise at law, or
(b) the number of residents residing in the home for the week, including absent residents. O. Reg. 246/22, s. 81 (5); O. Reg. 66/23, s. 17 (2).

The licensee has failed to ensure that a nutrition manager (NM) was on site at the home working in the capacity of NM for the minimum number of hours per week calculated under subsection (5), without including any hours spent fulfilling other responsibilities.

Rationale and Summary
With a licensed bed capacity of 160, the minimum number of hours calculated under subsection (5) was 51.2 hours per week. At 151, which was the number of residents residing at the home at the time of the inspection, the number of calculated hours was 48.3 hours per week.

The licensee's previous NM left their job on a day in July 2023, and the current NM was hired on a day in August 2023. Between the two dates, the corporate RD acted as NM.

The current NM worked full time as the lead of the nutritional care and dietary services program for the home. As the only NM, they were not able to be on site at the home working in the capacity of NM for the minimum number of calculated hours per week.

Not having a NM working for the minimum number of hours per week affected the optimal delivery of the nutritional care and dietary services program for the home as

supported by multiple Written Notifications being issued in this report.

Source: Interview with the NM.
[551]

WRITTEN NOTIFICATION: Safe storage of drugs

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (iv)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(iv) that complies with manufacturer's instructions for the storage of the drugs; and

The licensee has failed to ensure that the drugs stored in the medication refrigerator on a resident home area (RHA) were stored in compliance with manufacturers' instructions.

Rationale and Summary
The temperature monitoring log book for the medication storage refrigerator on an RHA was reviewed for a five month period in 2023. The temperature was first observed to be above eight degrees Celsius during the first month, when the temperature was recorded as 8.3 degrees Celsius. The temperature of the medication refrigerator was recorded to have remained above eight degrees Celsius throughout the first four months and up to a day in the fifth month, when the temperature was observed and recorded as thirteen degrees Celsius.

A pharmacist provided a report stating that three medications were stored in the RHA medication refrigerator during this five month period of time. The Pharmacist

stated the manufacturers' instructions for these medications stated they should be stored between two and eight degrees Celsius.

Failing to store medication at the required temperature as per manufacturers instructions created a risk of administering a medication that was not stable.

Sources: An RHA temperature log book; CareRx Policy 3.5 Medication Refrigerators, reviewed June 30, 2023; CareRx drug report; Observation of the RHA medication refrigerator; interview with the Pharmacist and other staff.
[756]

COMPLIANCE ORDER CO #001 Doors in a home

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure that unsupervised access to all non-resident areas is restricted for residents.

To meet this requirement:
A) Ensure that the doors leading to non-resident areas are locked when

unsupervised. This includes, but is not limited to, serveries, dish rooms, laundry chute rooms, housekeeping rooms, supply storage rooms and activity storage rooms.

B) Develop and complete daily audits, including on weekends and holidays, to ensure that all doors leading to non-resident areas are kept closed and locked (unless being directly supervised by staff). The daily audits shall be documented and shall be continued until such time that the Ministry of Long-Term Care has deemed that the licensee has complied with this order. Ensure the audits are done on different shifts.

C) Take immediate corrective action if doors leading to non-resident areas are found to be unlocked and not directly supervised by staff. Keep a documented record of the corrective actions taken.

The required documentation shall be kept until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds
1) The licensee has failed to ensure that doors leading to non-resident areas on a resident home area (RHA) were kept locked.

Rationale and Summary
An RHA storage room door in the activity lounge area and a storage room door in a resident hallway were observed to be unlocked and staff members were not present in either area. A Registered Practical Nurse (RPN) stated that both storage room doors were supposed to be locked as they should not be accessible to residents.

Failing to ensure the storage room doors were locked created a risk for residents with independent mobility to have unsupervised access to these areas.

Sources: Observations on an RHA; interview with an RPN.
[756]

2) The licensee has failed to ensure that all doors leading to non-residential areas were kept locked.

Rationale and Summary
The following doors leading to non-residential areas throughout the home were observed to be unlocked with no staff in the area supervising the doors:

- Second floor laundry chute room. There was tin foil covering the strike plate so the door lock could not engage. The laundry chute was therefore accessible to residents.

- An RHA housekeeping room. A Housekeeper indicated that the door handle used to be self-locking and therefore they did not think to check the door after closing it. There were cleaning chemicals within the room.

- An RHA activity storage room. The keys were in the door handle.

- The servery doors, within all five RHA dining rooms as well as the doors into the second floor dish room. The inspector observed that all equipment within the serveries was active and there was a hot water machine with a red spigot in each one. The temperature of the water from the red spigot was measured in one of the RHA serveries and it was 70.8C. Discussion with nursing staff and dietary staff served to confirm that the doors into the serveries from dining rooms were not kept

locked as a routine practice. A Dietary Aid (DA) indicated that sometimes if they are in the back dish room and residents are trying to wander in, they will lock the doors from within the servery and will later unlock the doors when they leave the dish room so nursing staff can get in.

- Servery doors, from two RHA dining rooms, three days after the first observation of unlocked and unsupervised servery doors. The Regional Director was with the inspector at the time of the observation. The Regional Director indicated that keys had been made for the servery doors and distributed to nursing staff. The Regional Director indicated that the expectation that servery doors be kept locked when staff were not present in the servery or the dish room had been communicated to staff. The Regional Director indicated they would follow up with regards to this recurrence.

As such, all residents with independent mobility were at risk as all could gain unsupervised access to high-risk non-residential areas.

Sources: Observations and interviews with nursing and dietary staff and the Regional Director.
[133]

This order must be complied with by January 15, 2024

COMPLIANCE ORDER CO #002 Communication and response system

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system

s. 20 (a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with [FLTCA, 2021, s. 155 (1) (b)]:

The licensee shall prepare, submit and implement a plan to ensure that the resident staff communication and response system can be easily seen, accessed and used by residents and staff at all times.

The plan shall include but is not limited to:
a) corrective actions to ensure that calls from residents' wristbands and from pullcords are cleared immediately after a call has been responded to.
b) corrective actions to ensure that at shift change, active calls are reviewed and any that have been responded to but can not be cleared are reported to management staff for follow up.
c) corrective actions to ensure that all care staff have a phone available to them or an alternate means of being immediately alerted to a call that has been made by a resident.
d) corrective actions to ensure that where care staff are to carry a phone, it is always sufficiently charged to last a shift and to be available for the next shift unless there are extra phones readily available.
e) corrective actions to ensure that where care staff are to carry a phone, the phone can remain connected to the Wi-Fi at all times and that staff can not be inadvertently logged out of their phone.
f) corrective actions to support residents that are hesitant to or unable to use pull cords at the bedside or at toilets due to the sound or due to an inability to reach a cord.
g) documented audits of the call bell response time records (from pull cords and

wrist bands) for one resident per resident home area per day (for the previous week) with documented follow up action to determine the root cause when delays in response have been recorded.
h) identification of management staff that is formally responsible for items a) through g).
i) randomized daily documented audits to verify that corrective actions taken for items a) through f) have been effective.

Audits shall continue, and documentation retained, until the Ministry of Long-Term Care has complied this order.

Please submit the written plan for achieving compliance for inspection 2023-1035-0003 to Jessica Lapensee, LTC Homes Inspector, MLTC, by email to OttawaDistrict.MLTC@ontario.ca by December 28, 2023. The compliance due date is February 15, 2024.

Please ensure that the submitted written plan does not contain any private information or personal health information.

Grounds
The licensee failed to ensure that there is a resident-staff communication and response system (RSCRS) that can be easily seen, accessed and used by residents and staff at all times.

Rationale and Summary:
Over the course of the inspection, staff and residents detailed numerous concerns about the RSCRS including: wait times in excess of 30 minutes for calls to be answered, a lack of available phones, insufficiently charged phones to last a shift, phones that did not make sounds to alert staff to a call and an inability to cancel

wristband calls with the staff pendants. If a wristband call was not cleared, the resident could not make another call.

Related to the availability of phones for care staff:
All care staff in the Resident Home Areas (RHAs) were required to have a phone in order to receive calls from the residents. Care staff doing one to one with a resident were the main exception.
- On a day in October 2023, two Personal Support Workers (PSWs) were not carrying their phones as none were available to them.
- On a second day in October 2023, a Registered Practical Nurse and a PSW were not carrying their phones as they had given them to other care staff.
- On a third day in October 2023, a PSW was not carrying a phone as none were available to them.

Related to the reliability of the phones and pendants:
- Four PSWs spoke to the inspector about their experiences with their assigned phones logging them out or being unable to maintain a Wi-Fi connection, which resulted in them not being alerted to calls from residents' wristbands or from pull cords.
- A PSW explained that their phone would not make a sound to alert them to calls and therefore sometimes residents had to wait a long time because they did not hear any alerts.
- Two PSW were carrying phones with insufficient charge to last their shift.
- A PSW explained that it can be very difficult to clear calls from wristbands because the ceiling mounted location monitors will not recognize the staff pendants. There was a call from an identified resident (the first identified resident) that had been active for three hours and a call from a second identified resident that had been active for one hour on their phone.
- A PSW explained that their phone only worked in some areas of the RHA.

Impact on residents:

A. On a day in October 2023, a PSW indicated that when they had started their shift, there had been an active call from the first identified resident's wristband for an hour which meant the resident could not have made another call during that time with their wristband. The PSW indicated that it is usually difficult to clear a call that the first identified resident has made from their wristband in their bedroom because the device on the ceiling does not register the pendants.

The "Momentum Healthware" printout of the first identified resident's calls for assistance from their wristband, from October 1 – 29, 2023 was reviewed. The review focused on examples of calls that were not cleared within at least 50 minutes. There were 66 such calls, and only one day on which this did not occur. There were 22 days with at least two calls that were not cleared within at least 50 minutes, with up to five such calls on one day. The longest calls were 16 hours 32 minutes, 6 hours 16 minutes, 5 hours 24 minutes and 4 hours 18 minutes.

B. On a day in October 2023, a PSW's phone was showing an active call from a third identified resident's wristband which had been active for two hours. The PSW indicated they had responded to the resident's call however they were unable to clear the call. The PSW confirmed that the third identified resident could not make another call from their wristband until the initial call was cleared. The inspector proceeded to the resident's bedroom and they were in their comfortable easy chair. The bedside pull cord was not within reach of the resident. When asked about their wristband the third identified resident said, "I'm supposed to push it and I do, sometimes it works and sometimes it doesn't". During the discussion, a PSW came into the bedroom to try clearing the active call with their pendant. As per the PSW's phone, the call from the third identified resident had been active for three hours.

The "Momentum Healthware" printout of the third identified resident's calls for assistance from their wristband, from October 1 – 29, 2023 was reviewed. The review focused on examples of calls that were not cleared within at least 30 min. There were eleven such calls, over nine days. Five of the calls were cleared after one to two hours and four of the calls were cleared after two to three hours.

C. A fourth identified resident indicated the following to Inspector #756: They wait a long time for their calls to be responded to, sometimes it's an hour before anyone comes. They use their wristband to make calls, not the bedside pull cord as they cannot reach it and their wristband is always accessible to them.

The "Momentum Healthware" printout of the fourth identified resident's calls for assistance from their wristband, from October 1 – 29, 2023 was reviewed. The review focused on examples of calls that were not cleared within at least 30 min. There were seven such calls, over seven days. Five of the calls were over an hour.

D. A fifth identified resident indicated the following to Inspector #756: At least once a week it takes up to an hour for their calls to be responded to. They hear from staff that they don't always receive residents' calls. In order to make a call, they use their wristband or the bedside pull cord. They make calls mostly from the wristband because the bedside call station makes a sound that they and their roommate find very irritating. While they are not supposed to get out of their bed on their own, there are times they have had to in order to cancel a call given the sound. There are times they press the button on the wristband and no one comes including within the last month.

The "Momentum Healthware" printout of the fifth identified resident's calls for assistance from their wristband, from October 1 – 29, 2023 was reviewed. The

review focused on examples of calls that were not cleared within at least 50 min. There were 16 such calls over 13 days. The longest call was six hours 56 minutes, followed by four hours 41 minutes. On one day in October 2023, there was a call that was not cleared until two hours 43 minutes and another not cleared until two hours 57 minutes.

E. On a day in October 2023, a PSW's phone was showing an active call from the fifth identified resident's wristband. The PSW explained they had responded to the resident however the call could not be cancelled. The fifth identified resident confirmed to the inspector that their needs had been addressed by a PSW however the call could not be cleared and they could not use their wristband. The resident explained they would not use the bedside pull cord as the sound really bothered their roommate. The resident reported that calls from their wristband were not going through to staff during the night between 0130 and 0330 hours and that this was a common problem. The fifth identified resident indicated that the night staff had been checking on them as they were aware of their recurring needs, noting that if it is regular staff they usually do checks on the resident.

F. On a day in October 2023, a PSW's assigned phone was showing an active call from a sixth identified resident's wristband. Another PSW was in the resident's bedroom trying to cancel the call with their pendant. The sixth identified resident indicated they rely exclusively on their wristband to make calls for assistance and they were not aware that they could not make a subsequent call if their initial call had not been cleared. The resident indicated there are times they wait a long time before their calls are responded to.

The "Momentum Healthware" printout of the sixth identified resident's calls for assistance from their wristband, from October 1 – 29, 2023 was reviewed. The review focused on examples of calls that were not cleared within at least 30 min.

There were 14 such calls over 12 days. The longest call was one hour 57 minutes.

G. A seventh identified resident indicated that they use their wristband to make calls for assistance however if no one comes then they pull the bedside pull cord however it makes a sound that is irritating to them and their roommate.

The “Momentum Healthware” printout of the seventh identified resident’s calls for assistance from their wristband, from October 1 – 29, 2023 was reviewed. The review focused on examples of calls that were not cleared within at least 30 min. There were eight such calls over eight days.

Failure to ensure that the RSCRS can be easily seen, accessed and used by residents and staff contributed to resident safety risks, resident stress and anxiety, and delayed staff responses.

Sources: Review of "Momentum Healthware" records for calls made from six identified resident's wristbands for the month of October 2023 and interviews with those residents, interviews with care staff and observations of referenced care staff phones
[133]

This order must be complied with by February 15, 2024

COMPLIANCE ORDER CO #003 Weight Changes

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 75
Weight changes
s. 75. Every licensee of a long-term care home shall ensure that residents with the

following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
a) Have a Registered Dietitian (RD), who is a member of the staff of the home and is on site at the home, complete the following:
b) Audit the body weight history of all residents, with identified risks relating to nutritional care, for a period of at least three months, starting with the most recent body weight.
c) Ensure that residents who have experienced body weight losses of 5 percent, or more over one month, or 7.5% percent, or more, over three months, are assessed by the RD using an interdisciplinary approach, and that actions are taken and outcomes are evaluated.
d) Document the action(s) taken, under b, c and e.
e) The RD will evaluate the outcomes of the action(s) taken and document the effectiveness of the action(s) and if further action(s) is warranted.

Grounds
The licensee has failed to ensure that a resident was assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated when their body weight declined.

Rationale and Summary
The resident's weight was recorded upon admission. The month after admission, the resident's weight was not recorded. The second and third month after admission, the resident's weight was recorded.

The resident's weight declined 6.2% from the date on which they were admitted to the second month after admission. The resident's weight declined another 3.3% between the second and third month after their admission. On a day in the third month after admission, an intervention was ordered.

The RD stated that between the resident's admission date and the third month after their admission, no actions were taken to address the resident's continued weight loss.

Failure to take action to address the resident's continued weight loss may have compromised the resident's quality of life.

Sources: A resident's health care record and interview with the RD.
[551]

This order must be complied with by January 26, 2024

COMPLIANCE ORDER CO #004 Orientation training

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 82 (2)
Training
Orientation
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and

neglect of residents.
4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

A) Provide the identified Registered Nurse (RN) with the required orientation training for all subsections listed in FLTCA, 2021, s. 82 (2).

B) Provide the identified Environmental Services Manager with the orientation training required under FLTCA, 2021, s. 82 (2) 10. on the FLTCA, 2021, and O. Reg. 246/22.

C) Complete an audit of the orientation training of all staff hired from August 1, 2023, to the time this inspection report is served. For any staff member identified to have not completed the required orientation training in FLTCA, 2021, s. 82 (2), complete the required training immediately.

A written record must be kept of everything required under (A), (B), and (C), until the Ministry of Long-Term Care has determined the licensee has complied with this

order.

Grounds
1) The licensee has failed to ensure that an identified RN completed the required training prior to performing their responsibilities.

Rationale and Summary
The Surge Learning Education Status Report, 2023, was reviewed for the identified RN who had a starting date in the summer of 2023. It was identified that the RN had only completed three percent of the required training, which included some of the training on cultural competence and emergency codes. Further, the RN had not completed the Mandatory Orientation Checklist and there was no documentation available that showed attendance at the general orientation.

The DOC confirmed that the RN was currently working in the home and acknowledged they had not completed the required orientation training prior to performing their responsibilities.

The impact of staff not completing their orientation training, prior to performing their responsibilities, placed residents at risk.

Sources: Surge Learning Education Report; interview with the DOC.
[756]

2) The licensee failed to ensure that the Environmental Services Manager (ESM) received training in the Fixing Long-Term Care Act, 2021 (FLTCA, 2021) and Ontario Regulation 246/22 (O. Reg. 246/22) prior to performing their responsibilities.

Rationale and Summary

On a day in October 2023, the inspector met with the ESM. They indicated they were not familiar with the FLTCA, 2021 and O. Reg 246/22. The ESM was informed by the inspector how to access the FLTCA, 2021 and O. Reg 246/22 through the government of Ontario website "e-Laws". Several sections of the FLTCA, 2021 and O. Reg. 246/22 that relate to the required programs of housekeeping, laundry and maintenance were pointed out to the ESM by the inspector.

On a day in October 2023, the inspector requested the EMS's orientation records from the Director of Care. Later that day, the inspector was provided with a document titled the "Environmental Service Manager Orientation Guide" which had been signed by the ESM on the day it had been requested. The document was also signed and dated on the day it had been requested by the onsite Southbridge Environmental Consultant. It was noted that there were a number of items not checked off. The ESM explained that they had only checked off the items that the former Administrator had shown them, on their start day in the summer of 2023.

As per review of the document and interview with the ESM, it was confirmed that the ESM had not been trained in the area of the FLTCA, 2021, and O. Reg 246/22 prior to performing their responsibilities.

The impact of staff not completing their orientation training, prior to performing their responsibilities, placed residents at risk.

Sources: Review of the "Environmental Service Manager Orientation Guide" and interview with the ESM.
[133]

This order must be complied with by January 15, 2024

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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