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
Jul 30, 2020	2020_837750_0005 (A1)	000376-20, 001127-20, 002054-20, 003293-20	Complaint

Licensee/Titulaire de permis

Maplewood Nursing Home Limited
73 Bidwell Street TILLSONBURG ON N4G 3T8

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

Cedarwood Village
500 Queensway West SIMCOE ON N3Y 4R4

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

Amended by STACEY GUTHRIE (750) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

Please note the number of beds for the home was amended to 90 beds.

Issued on this 30th day of July, 2020 (A1)

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

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

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

Amended by STACEY GUTHRIE (750) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 19, 20, 21, 24, 25, 26, 27, 28, and March 2, 3, 4, 5, 6, 9, 10, 11, 12, 13, 2020.

The following intakes were completed during this critical incident inspection:

Log #003293-20 related to personal support services,

Log #000376-20 related to sufficient staffing,

Log #001127-20 related to personal support services and continence care, and

Log #002054-20 related to personal support services.

This inspection was completed concurrently with critical incident inspection #2020_837750_0004.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Coordinator, Resident Assessment Instrument (RAI) coordinator, physiotherapist (PT), Behavioural Support Ontario (BSO), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW) and residents.

During the course of this inspection, the inspector (s) observed the provisions of resident care, reviewed clinical health records, investigation notes, staffing schedules, meeting minutes, policies and procedures and the home's internal complaint log.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Nutrition and Hydration
Personal Support Services
Snack Observation
Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.
- **14 WN(s)**
- **5 VPC(s)**
- **7 CO(s)**
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out clear direction regarding foot care to staff and others who provide direct care to the resident.

A complaint was submitted to the Director on a specified date, regarding concerns about resident #001's personal hygiene including foot care. The complainant noted that the home had a change with the external foot care provider in an identified month and during the transition period, resident #001 did not receive foot care.

A) A review of resident #001's written plan of care found an intervention indicating that foot care was to be completed by external provider, with an initiated date noted.

In the Point of Care (POC) tasks, for bathing, there was a question noted for all residents regarding foot care that was contradicting.

In an interview with Personal Support Worker (PSW) #100, they confirmed that there was a change with the external provider in an identified month and there was a delay with the new provider initiating services in the home. PSW #100 confirmed that they will perform foot care to residents on their identified bath day if required including resident #001, even if they are identified as receiving external services. PSW #100 also acknowledged that they will document yes to the POC question noted above even when the task was not performed, as that was the direction provided by management.

The Director of Care (DOC) #104 provided a piece of paper with a note from Point Click Care (PCC), with an identified date, from the administrator regarding resident's foot care, which was contradicting to the POC task noted above.

In an interview with DOC #104, they confirmed that there was a change in the home's external foot care provider in an identified month and due to outbreak and miscommunication, there was a delay in the new provider initiating the services in the home. DOC #104 confirmed that staff would not know to perform foot care to resident #001, when the external service provider was not available as it was documented in their plan of care to be completed by external provider. DOC #104 confirmed that the direction was unclear for staff.

The DOC #104 confirmed that any resident who was identified as having external foot care services would not have clear direction based on the conflicting information between the care plans and the POC task.

The home failed to ensure that there was a written plan of care for resident #001 that set out clear directions to staff and others who provide care to the resident.

Resident #006 and #007 were randomly selected as residents identified to receive external foot care services.

B) A review of resident #006's written plan of care noted that their foot care was to be provided by an external care provider, with an initiated date noted. An additional intervention for foot care to be provided by an external provider was initiated on a specified date.

In an interview with PSW #133, they explained that they assess any resident when they perform baths to see if they require foot care and will perform if necessary, including those identified on the list for external foot care. PSW #133 confirmed that they have in the past provided foot care for resident #006.

In an interview with RPN #135, they acknowledged that resident #006 was on the list for foot care services. RPN #135 noted that they had never provided footcare to any resident in the home and were not sure who the current provider was or when they were in the home.

In an interview with Administrator #105 and DOC #104 they acknowledged that the POC task was assigned to every resident, that the list of residents' receiving external foot care services was not updated or shared with staff and confirmed that clear direction was not provided to staff regarding residents' foot care in the home.

The home failed to ensure that there was a written plan of care for resident #006 that set out clear directions to staff and other who provide care.

C) A review of resident #007's written plan of care identified in their care plan that foot care was to be provided by an external provider, with an initiated date included and another intervention that noted foot care routinely provided by an external provider with an initiated date as well.

In an interview with PSW #100 and PSW #133, they acknowledged that they will provide footcare to residents if they need it including those who are on the list for external foot care services.

In an interview with Registered Practical Nurse (RPN) #135 and registered nurse (RN) #106 they both confirmed that there was a change in the foot care service provider in the home, that the posted list was out dated and they were not aware of the current residents who were receiving external foot care services in the home at the time of the inspection.

In an interview with Administrator #105, they advised that the new external foot care service provider provides a list of the residents being seen during the dates the provider will be in the home via email. Administrator #105 noted that they believed residents on the list would not be getting their foot care completed by

PSW staff. Administrator #105 acknowledged that the list was not being communicated with the staff identifying the new service providers list and corresponding schedule.

The DOC # 104 confirmed that staff were not given clear direction regarding resident #007's foot care.

The home failed to ensure that there was a written plan of care for resident #007 that set out clear directions to staff and other who provide care.

2. The licensee failed to ensure that the care set out in the plan of care for resident #011, related to assistive devices at meals, was based on an assessment of the resident and the needs and preferences of that resident.

The plan of care for resident #011 was revised on a specified date, to include the addition of an assistive device for the resident. During interview with Inspector #107 on an identified date, the Registered Dietitian (RD) #125 confirmed that the assistive devices were added to the resident's plan of care without an assessment of the resident and at the request of nursing staff. RD #125 confirmed that the resident was not observed or assessed with the devices prior to adding them to the resident's plan of care.

At the lunch meal on a specified date, resident #011 was observed by Inspector #750. Resident #011 had an assistive device and was experiencing difficulty navigating the device.

At the lunch meal on another specified date, resident #011 was observed by Inspector #107 having difficulty with another assistive device. The resident repeatedly attempted to use the assistive device and was unsuccessful. After repeated tries, PSW #100 came to assist the resident.

The care set out in the plan of care for resident #011 related to assistive devices was not based on an assessment of the resident and the needs and preferences of the resident.

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the personal hygiene strategies set out in the plan had not been effective.

A complaint was submitted to the Director on a specified date, regarding concerns about resident #001's personal hygiene.

A review of resident #001's written plan of care found strategies identified for bathing. A review of resident #001's , electronic medication administration record (eMAR) for an identified month, did not have an order as noted in resident's plan of care.

In an interview with PSW #100, they acknowledged that the home had tried different identified strategies with resident #001, and they were ineffective.

In an interview with registered practical nurse (RPN) #102, they acknowledged that the identified strategies for bathing were in resident #001's plan of care and RPN #102 confirmed that the mentioned strategies were no longer effective and should have been removed from the resident #001's plan of care.

The home failed to ensure that when resident #001 was reassessed, their plan of care was reviewed and revised when the care set out in the plan was no longer effective.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were provided with food and fluids that were safe, nutritious, and varied.

A) Fluids served to residents were not always safe and were not consistent with the residents' required diet order.

Direction for thickening beverages was included on the containers of thickener provided in each dining room, however, plastic containers of thickener in the dining rooms and containers on the snack carts did not include directions for staff on the quantity of thickener to provide for the desired thickness.

Multiple staff providing thickened beverages to residents throughout the inspection stated to Inspectors #107 and #750 that they were unclear on the required amount of thickener to be added to beverages and unclear on the size of cups, specifically adaptive devices, that were provided to residents.

a. At the lunch meal on an identified date, staff # 114 did not know how much thickener to add to resident #022's beverages. The staff were using a large plastic container of thickener and plastic spoons to portion the thickener and directions were not included on the container.

b. At the lunch meal on an identified date, PSW #127 stated they were guessing on the amount of thickener for resident #025. PSW #127 and PSW #126 were unclear the size of each assistive device cup. Directions provided on the can of thickener identified the required amount of thickener for certain size cups.

c. At the afternoon snack pass on an identified date, staff #123 stated they were unsure on how much thickener to add to resident beverages. There was no direction provided for staff on the container of thickener or anywhere on the snack cart related to thickening fluids. A measuring spoon was not available on the snack cart and staff were observed using a plastic disposable spoon for portioning

the thickener. Resident #004 and resident #025 both required the same consistency thickened fluids, however, PSW #129 added 1 plastic spoonful of thickener and PSW #121 added 3 large metal teaspoons.

d. At the lunch meal on an identified date, staff #114 staff did not use a measuring spoon for thickening the beverages for resident #009. The staff followed the directions on the container of thickener for number of scoops of thickener, however, staff used a disposable plastic spoon to portion the thickener, which was a different quantity than the measuring spoon inside the can of thickener.

e. Resident #009 required thick consistency fluids. The resident had a Physician's order for a nutritional supplement, to be provided twice daily, and thickened to the required consistency.

At the lunch meal on an identified date, RPN #119 confirmed that the supplement provided to resident #009 was not thickened and was not the required consistency identified in the resident’s plan of care. Directions on the package of thickener identified that supplements required 15-20 minutes to thicken to reach the desired consistency. During interview with Inspector #107, the Nutrition Manager #120 stated that they had not discussed this issue with the nursing department to ensure that adequate time was available for thickening the product.

f. At the observed afternoon snack pass on an identified date, resident #009 was served a beverage that was thinner than the consistency identified in their plan of care. PSW #130 who prepared the beverage stated that the resident had been stating that their beverages were too thick so they thickened it less. Consultation with Registered staff did not occur prior to providing the beverage that was incorrectly thickened.

g. Not all fluids on the table for resident #030 were thickened. A glass of an identified beverage had been thickened, however, a second glass of an identified beverage was left un-thickened in-front of the resident until right at end of meal service. Staff did not ensure that all fluids portioned and placed in-front of the resident were safe for the resident to consume.

B) Residents requiring a pureed menu were served food and fluids that were unsafe and had reduced nutritive value.

The pureed salad at the lunch meal on an identified date, the afternoon pureed

snack on another identified date, and the pureed entrée and pureed dessert at the lunch meal on a different date, were noted to be a thin consistency and running over the plates/bowls. Preparation of pureed texture items to the correct consistency ensures that nutritive value is maintained (not diluted with too much fluid), that food is safe for residents who have difficulty swallowing.

At the lunch meal on a specified date, PSW #146 stated to Inspector #107 that the pureed food was usually thicker.

At the lunch meal on a specified date, the Nutrition Manager #120 stated that they noticed that the food was too runny on an identified unit and additional thickener was added. In an identified dining room, staff did not add additional thickener prior to serving the items to residents. Resident #009, who required thickened fluids started coughing when they were assisted with eating the pureed dessert. The resident was unable to continue eating the dessert due to the coughing. Resident #030, who also required thickened fluids, started coughing when consuming the pureed dessert. The resident was also unable to continue eating the dessert due to coughing and the item was removed.

At the lunch meal an identified date, the pureed salad was not smooth and appeared a bit chunky. PSW #131 confirmed that the salad was a bit chunky but that the salad was difficult to puree.

C) Food served to residents requiring a pureed menu were not always varied. The planned menu for the an identified date supper meal included a particular item for dessert. At the observed supper meal, a pureed option of the dessert was not available for the pureed texture menu. An alternate pureed dessert (the same item that was served at the prior lunch meal) was substituted and served to residents requiring a pureed menu.

During interview with Inspector #107 on a specified date, Dietary Aide #115, who prepared the dessert, confirmed that they used leftovers for the dessert. The Dietary Aide stated that insufficient dessert was available to prepare all textures so the leftover alternate dessert was used for the pureed dessert. The Dietary Aide did not document the substitution and it was not communicated to the Nutrition Manager #120 so they could adjust the food order. The food served to residents requiring a pureed texture menu was not as varied as on the planned menu.

D) The nutritive value of fluids offered at snacks was not maintained for residents at high risk for weight loss and those residents receiving nutritional supplementation for additional calories. Diet drink crystals were served to those residents at the observed evening snack pass on a specified date. During an interview with Inspector #107 on an identified date, Nutrition Manager #120 confirmed that only diet crystals were offered on the snack carts and were provided to residents at nutrition risk and those requiring nutritional supplementation.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section. 2007, c. 8, s. 76. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff received training as required by this section.

The licensee failed to ensure that no person mentioned in subsection (1) performed their responsibilities before they received training in the areas mentioned below.

In accordance with O. Reg 79/10 s. 222 (1) (a), a licensee of a long-term care

home is exempt from the requirements under section 76 of the Act with respect to persons who fall under clause (b) or (c) of the definition of "staff" in subsection 2 (1) of the Act.

LTCHA, 2007, s. 2 (1) defines staff as persons who work in the home, (c) pursuant to a contract or agreement between the licensee and an employment agency or other third party.

In accordance with O. Reg 79/10 s. 222 (2), the licensee shall ensure that the persons described in clauses (1) (a) to (c) are provided with information about the items listed in the following paragraphs:
1. The Residents' Bill of Rights,
2. The long term care home's policy to promote zero tolerance of abuse and neglect of residents,
3. The duty under section 24 to make mandatory reports,
4. The protectors afforded by section 26,
5. Fire prevention and safety,
6. Emergency and evacuation procedures, and
7. Infection prevention and control,
of subsection 76 (2) of the Act before providing their services.

The Director of Care (DOC) #104, reported that the home had no formal orientation, training package or related material and no method of training any of the agency staff coming into the home. The DOC confirmed that the home does call on three different agencies for both personal support workers (PSW) and registered practical nurses (RPN) when the home is unable to find staff to fill shortages; A Supreme Nursing and Home Care, Paramount Care Nursing Agency and Lifeguard Homecare.

In an interview with agency PSW #151, on a specified date, while they were working in the home, they confirmed that they did not receive any training when they came to the home. They described their orientation to involve another PSW showing them around the unit, going over what they were to do and advising where items that may be required were located on the unit. PSW #151 confirmed that they did not review any policies or complete any formal training regarding the outlined training requirements in the Long Term Care Homes (LTCH) Act.

RPN #116, who was an employee of the home, noted that they train all agency

registered staff coming into the home by providing an overview of the home's medication system, noting that the home had recently changed pharmacy providers. RPN #116 explained that if an agency RPN has not been to the home before, some will come in an hour early to review the processes in the home. RPN #116 confirmed that this was at the discretion of the agency staff, not expected or directed by the home.

In an interview with both Agency Manager #152 and #153, they confirmed that training was to be completed by the home requesting their staff. They did confirm that they complete criminal reference checks on their staff, and both noted that they recently received a request from DOC #104 for record of these criminal reference checks.

The Clinical Coordinator #149 acknowledged that all of the home's training is completed face to face and provided an outline of the areas covered in an excel document as well as a sample agenda for the general orientation. The clinical coordinator #149 explained they were working on the development of a training package for agency staff including the logistics of who would be providing the training and confirmed that the home did not have this in place at the time of the inspection.

The home failed to ensure that all agency staff working in the home received training in the areas mentioned above before they performed their responsibilities.

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

(A1)
The licensee failed to ensure that the home had a written staffing plan regarding the organized program of nursing and personal support services required under clause 8(1) (a) and (b) of the Long Term Care Act, and the staff plan must:

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

A complaint was submitted to the Director on an identified date, related to 24 hour nursing care. Additionally, three other complaints were submitted to the Director

in two identified months, including concerns regarding staffing.

Cedarwood Village is a Long-Term Care Home (LTCH) with a licensed capacity of 90 beds, with 45 residents on the first floor and 45 residents on the second floor. The licensee used a "Daily Assignment Sheet" which had the following staff mix over a 24 hour (hr) period for Registered Nurses (RN), Registered Practical Nurses (RPN) and Personal Support Workers (PSW):
RN's - three staff per day, scheduled from 0600 to 1400 hrs, 1400 to 2200 hours and 2200 to 0600 hrs.
RPN's - First floor, two staff per day, scheduled from 0600 to 1400 hrs and 1400 to 2200 hrs.
- Second floor, two staff per day, scheduled from 0600 to 1800 hrs and 1800 to 0600 hrs.
(expect Fridays where three 8hr shifts of RPNs were scheduled)
PSW's - First and second floor each had 12 staff per day, five staff scheduled from 0600 to 1400 hrs, five staff from 1400 to 2200 hours and two staff from 2200 to 0600 hrs.

1. In interviews with the Administrator and Director of Care (DOC) it was confirmed that the identified staffing mix current, and it was the staffing mix in place at the time of the inspection that was required to meet the residents' assessed care and safety needs.

A. The planned staffing mix for RN's in the home, for the direct care of residents, was three Registered Nurses (RN) for a total of 24 hours per day, as identified on work schedules provided by the home and confirmed by the Ward Clerk.

During an interview with the DOC on an identified date, they confirmed the home did not have RN coverage for eight shifts between three identified months.

In an interview with the Administrator, they confirmed that the home did not have a documented process setting out the organization and scheduling of registered staff shifts. Additionally, the Administrator confirmed that the home did not have a written back up plan for nursing that addressed situations when staff, including those who must provide the nursing coverage required under subsection 8(3) of the Act, cannot come to work.

B. The planned staffing mix for RPNs in the home for direct care of residents, was two RPNs working on each floor (totaling four) on Saturday through Thursday, and

on Fridays each week, there should be three RPNs working on the second floor and two RPNs on the first floor (totaling five).

A review was conducted of the staffing levels on select dates in three identified months, as the complainants identified that staff shortages occurred during this time, noting two separate outbreaks that contributed additionally to staff shortages.
The review identified seven incidents were the home was short at least one RPN during the identified months.

As noted above, in an interview with the Administrator on an identified date, they confirmed that the home did not have a written process to set out the organization and scheduling of registered staff shifts or a backup plan for nursing staff that addressed situations when staffing, including those who must provide the nursing coverage required under subsection 8(3) of the Act, cannot attend work.

C. The planned staffing mix for PSWs in the home for direct care of residents, was five PSWs working on each floor of the home on day and evening shifts (totaling ten), and two PSWs working on each floor on the night shift (totaling four).

A review was conducted of the staffing levels on select dates in three identified months, as the complainants identified that staff shortages occurred during this time, noting two separate outbreaks that contributed additionally to staff shortages.

It was identified through staffing records that there were 27 dates between three identified dates, where the home was short PSW shifts.

Interviews were conducted with PSWs #107 and #118, they confirmed PSW staff were often not able to meet all of the residents care needs as per the residents plan of care when the home had significant PSW shortages.

2. While inspecting the following resident care needs were noted and their actual and potential impacts to the care of residents were identified:

A. A review of the home's bathing records for three identified months, was completed. It revealed that all residents on the first floor missed their scheduled baths on the six identified dates.

During an interview with Quality Improvement, they confirmed that the scheduled baths on the identified dates were missed and not made up due to staff shortage.

B.
i) The Home's policy "NDM-III-114, Meal Service - Pleasurable Dining ", with an identified date, was reviewed and stated that residents were to be attended by at least one staff member while in the dining room.

At a number of observed meal services on identified dates, in identified Dining rooms, residents were observed eating and drinking while staff were not in the dining rooms. Staff were observed transporting residents to their rooms or completing other duties outside the dining area while residents were still eating and drinking. Inspector #107 was in the dining room and observed that staff were not always within a visual or auditory range of the dining room.

At the supper meal an identified date, PSW #137 stated that they didn't want to rush the residents so they were leaving the residents alone to finish their meals. Resident #026 required assistance with eating and drinking and verbal prompting during the meal. Staff had left the dining room prior to the resident finishing their meal and were in and out of the dining room for extended periods. At 1800 hours another PSW #121 came back to the dining room and assisted the resident to finish their meal and beverages.

During interview with Inspector #107 on an identified date, Director of Care (DOC) #104 confirmed that at least one staff was required to be in the dining room while residents were eating and drinking.

ii) On an identified date, the daily assignment sheet, which outlined staffing for the day, indicated that the floor was short two personal support worker (PSW), leaving three PSWs for the evening shift. The full complement of staff for the evening shift on an identified unit was five PSWs. On an identified unit there are three dining rooms, each with approximately 12 residents. Dining room 5 has the greatest number of residents requiring assistance.

During an observation of a supper meal service on an identified date, in dining room 5 on the second floor, inspector #750 witnessed PSW #134 simultaneously assisting residents #004, 021, 022, 023 and 024, who were set at two separate

tables, while also clearing plates, serving dessert, cuing and assisting other residents in the dining room. PSW #134 was the only staff in addition to the dietary aid, who was serving residents meals and left the dining room as soon as all resident's had received their meals, in the dining room during the observation.

A review of the observed resident's assistance requirements found resident #004 and resident #024 required one staff extensive assistance with eating, resident #022 required total assistance with eating, resident #021 required set up with observation, staff to feed part of meal when required and resident #023 required set up assistance and supervision with guidance to complete task including staff placing items into resident's hand.

In an interview with PSW #134, they confirmed that when the home is short staffed and there are only three PSWs working, there are three dining rooms on the floor, which need each PSW to attend a dining room. PSW #134 acknowledged that when there is only one staff in each dining room, that requires assisting multiple residents at one time with eating and drinking. PSW #134 confirmed that due to being short staff on the identified date, during the supper meal they had to assist more than two residents at one time.

iii) At an observed lunch meal on an identified date, resident #011 had an assistive device. The resident was unable to successfully use the noted assistive device. PSW staff were in and out of the dining room and were not assisting the resident. Eventually, PSW #100 then came and assisted the resident.

At an observed supper meal on an identified date, Inspector #107 observed the resident having difficult with their meal. A good portion of the resident's meal and dessert had spilled onto the resident's lap.

Resident #011 was identified at nutrition risk and the resident had unplanned weight loss below their goal weight range. The resident's plan of care directed staff to support resident with fluid and food consumption. Documentation in the resident's progress notes and interview with the Registered Dietitian #125 reflected the resident was not receiving the required level of assistance with eating at meals and snacks due to an outbreak situation where staff were unavailable to provide the level of assistance with eating the resident required, resulting in weight loss.

The home was below the planned staffing complement for PSW staff on both the

morning and afternoon shift for the first floor on the identified date noted above.

iv) At the observed lunch meal an identified date, resident #031 used items used by resident #032, creating cross contamination. PSW staff#107 that was assisting at the table had left the table to help another resident and no staff were assisting at the table. Resident #031's dessert and plates were removed when staff returned to the table without further assistance being offered.

The plan of care for resident #030 directed staff to provide a pureed texture snack for the resident. Staff delivering the identified date, afternoon snack cart ran out of bowls for the pureed snack so the resident's snack was placed in a 125 millilitre plastic cup (difficult to maneuvre a spoon into the small opening and deep cup). A thickened beverage was placed in the resident's hand, however, the pureed snack was placed on a table in the resident's room. The resident was unable to reach the table and did not consume the snack. Staff did not return to the room to assist the resident with their pureed snack and the snack remained uneaten on their table until it was collected by staff at the evening snack pass.

The plan of care for resident #030 identified the resident was at high nutritional risk. At the observed lunch meal on an identified date, the resident repeatedly attempted to drink their glass of thickened beverage. The resident was unable to tip the glass up to get the last 1/3 of the beverage from the glass. The resident would pick up the glass, attempt to drink and then put down the glass several times without successfully drinking the rest of the beverage. Staff assistance was not provided. The resident had another beverage sitting on the table in-front of them, however, the second beverage had not been thickened. PSW #112 noticed a beverage was not thickened at 1258 hours and the resident was able to drink some of the beverage at the end of the meal service. The home's policy for thickened fluids that was provided to Inspector #107 stated that all beverages at the table were to be thickened at the same time when placed on the table for residents to ensure the safety of the resident. The resident had not been assisted with thickening the beverage for almost one hour.

The resident sat with their dessert in-front of them and assistance was not offered to the resident. The resident did not have a spoon at their place setting when the dessert was placed on the table. Inspector #107 requested a spoon for the resident at 1258 hours and the resident was assisted with their dessert ten minutes later.

The home was below the planned staffing complement for PSW staff on both the morning and afternoon shift for the first floor on an identified date.

v) On an identified date, at approximately 1450 hours, a pureed snack and drink were left on a bedside table that was not within reach of resident #036. The resident was sleeping when the snack was left at the bedside and staff did not return to the resident's room prior to getting the resident up for the dinner meal at 1650 hours. The resident was awake when observed by Inspector #107 at 1635 hours. Inspector #107 asked the resident if they had been offered a snack or beverage and the resident stated they had not been. The resident stated they were hungry and thirsty when asked by the Inspector and stated that they were not usually offered a snack in the afternoon. The untouched snack remained at the bedside when the resident was taken to the supper meal.

The plan of care for resident #036 identified the resident required set up assistance for eating.

The home was below the planned staffing complement for PSW staff on both the morning and afternoon shift for the first floor on the identified date.

vi) Inspector #107 observed resident #035 at the lunch meal and afternoon snack pass on an identified date. At the lunch meal the resident sat without consuming their beverages or dessert for an extended period (more than 15 minutes) and the resident's apron was removed. When Inspector #107 asked the resident about their beverages and dessert the resident stated they would take some but required assistance. When PSW #112 was asked by Inspector #107 to provide assistance, the resident consumed additional food and fluids.

At the observed snack service, a sealed snack and a glass of water were left on a bedside table for the resident #035 at 1440 hours. Inspector #107 remained on the unit and Inspector #107 did not observe staff returning to the resident's room to assist the resident with their snack. At 1630 hours, the resident's snack remained untouched and was in the same spot as when it was dropped off for the resident at 1440 hours. When asked by Inspector #107, the resident confirmed they required assistance with the snack. Inspector #107 asked the resident if staff came to assist the resident with their snack and the resident confirmed that they had not been offered assistance with their afternoon snack. Inspector #107 asked the resident if they would like a beverage and the resident replied, "that would be nice". When Inspector #107 asked if the resident would like their snack the

resident stated they would try it. Inspector #107 informed PSW #130 who then went to assist the resident just prior to the dinner meal. The PSW stated the resident took some sips of water and the PSW brought the resident's cup of water to the dining room for the supper meal. The snack remained unopened.

The home was below the planned staffing complement for PSW staff on both the morning and afternoon shift for the first floor on the identified date.

C. During an interview with Registered Dietitian #125 on two specified dates, they confirmed that there were large gaps in the food and fluid intake documentation, resulting in lack of information for nutritional assessments and for the evaluation of the effectiveness of nutritional interventions. The nutrition and hydration program at the home was unable to identify risks related to nutrition and hydration and did not allow for the evaluation of food and fluid intake of residents with identified risks related to nutrition and hydration.

Nutrition and hydration risks observed by Inspector #107 in the dining room or at snack service were not identified in food and fluid intake documentation, progress notes, or through referrals to the Registered Dietitian.

i) Resident 008 had a plan of care that directed staff to provide an identified food item at an identified snack pass. On five out of six days reviewed between two identified dates, prior to a nutrition assessment, the resident's identified snack intake records reflected not applicable, or the information was incomplete, resulting in the inability to evaluate the effectiveness of the strategy from the available documentation.

ii) Documentation on resident #035's food and fluid intake records was incomplete with 32% of meals and 44% of snacks not recorded for an identified month, effecting the evaluation of the resident's nutrition and hydration.

iii) Documentation on the resident #032's food and fluid intake records was incomplete with 28% of meals and 39% of snacks not recorded for an identified month, effecting the evaluation of the resident's nutrition and hydration. Documentation of the resident's hydration for an identified two weeks, reflected intake less than their fluid requirement on 24/32 days, and less than 75% of their fluid requirement on 19/32 days, however, documentation was incomplete and it was unclear what the resident's actual hydration pattern was. Concerns could not

be accurately identified from the documentation available.

iv) Documentation on the resident #036's food and fluid intake was incomplete with 45% of snacks not recorded for an identified month, effecting the evaluation of the resident's intake and hydration level, including the provision of snacks.

v) Documentation of the resident #30's food and fluid intake records was incomplete with 26% of meals and 49% of snacks not recorded for an identified two week period.

vi) Documentation of the resident #009's food and fluid intake records was incomplete with 24% of meals and 42% of snacks not recorded for an identified month.

Documentation for most of the residents reviewed was missing on five identified dates.

On an identified date, the home was below the usual staffing complement by two PSWs and an RPN on the day shift for the first floor, one PSW on days for the second floor, two PSWs for the afternoon shift on the first floor and one PSW for the afternoon shift on the second floor.
On an identified date, the home was below the usual staffing complement by one staff on the first and second floors for the day shift, one PSW for the first floor and two PSWs for the second floor afternoon shift, and one PSW for the evening second floor shift.
On an identified date, the home was below the usual staffing complement by two PSWs on the first floor and second floor day shifts, one PSW for the afternoon shift on the first and second floors.
On an identified date, the home was below the usual staffing complement by one PSW on the first floor day shift, one PSW on the second floor afternoon shift.
On an identified date, the home was below the usual staffing complement by one PSW on the first floor day shift, and one PSW on the first floor afternoon shift.

During interview with Inspector #107, PSW #147 stated they were unable to get all the documentation completed when staffing was below the usual complement.

3. Inspector # 750 requested to see the licensee's written staffing plan for the organized program of nursing and personal support to identify if the requirements

in O. Reg 79/10, s 31(3) were included.

A binder identified as "Shift Routines" was provided and confirmed to be the home's staffing plan by the Director of Care (DOC) #104 on an identified date.

The binder contained a "Personal Support Workers (PSW) Working Short Algorithm", dated January 2019, that provided steps to be taken in the event of a sick or absent call in. There was no such algorithm found for registered staff. Additionally, the binder was divided into bath PSW, PSW days, evenings and nights, Registered Practical Nurses (RPN) and Registered Nurses (RN). Within each identified section was an outline of the identified roles' shift duties, including day (0600-1400) and evening (1400-2200) shifts for PSWs, when full staff, which was five (5) staff, short one PSW leaving four (4) staff, and short two PSWs, leaving three (3) staff for each floor, PSW night (2200-0600) and bathing shifts (0600-1400 and 1400-2200). RPN routines included day/evening (0600-1800), night (1800-0600) for both floors and additional routines for Fridays on the second floor for days (0600-1400) and evenings (1400-2200); it was noted on the RPN night shift routine, to assist with PSW rounds and break coverage if short PSWs. RN day (0600-1400), evening (1400-2200), and nights (2200-0600) were in the binder and on each of the shift routines, it noted if short an RPN, a RN will assume the RPN's duties.

The binder did not include:
-a written plan that set out the organization and scheduling of staff shifts;
-a written plan that identified how the home promotes continuity of care, minimizing the number of different staff members who provide nursing and personal support services to residents in the home;
-a written backup plan for nursing and personal care staff; or
-written updates or evaluations of the staffing plan.

In an interview with the Administrator #105, they confirmed that the home did not have the identified areas included in the home's staffing plan, as noted above.

In summary, over the course of the inspection, the licensee did not meet the staffing mix set out by the home, did not meet the assessed care and safety needs of the residents and did not ensure a staffing plan was in place in the home.

The licensee failed to ensure that the home had a written staffing plan that included the home's process for scheduling staff shifts, how the home minimizes the number of different staff members and continuity of care, a backup plan that outlines the expectations set out in the Long Term Care Homes Act s.8(3) and an annual evaluation of the plan.

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

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1.The licensee failed to ensure that each resident in the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a

medical condition.

A complaint was submitted to the Director, regarding concerns about resident #001's personal hygiene.

The home's bathing paper documentation for identified months were reviewed. The review identified two weeks, in two separate months, which each had three dates, Thursday AM, PM, Friday AM, PM and Saturday AM, PM, that were blank for all residents on an identified unit.

In an interview with the Quality Improvement staff #103, they confirmed that if dates were not identified on the sheet then baths did not occur that day. They also noted that during the identified dates in the identified months, baths did not occur due to the home being short staff and that residents would not have received their baths twice a week.

The home provided copies of the daily assignment sheet during the identified weeks for both months. The full staffing compliment for day and evening shifts included five (5) PSWs; one PSW assigned to bathing and four PSWs to manage care.
The following dates were identified for the identified unit:
On an identified date, the home was below the usual staffing compliment by two PSWs on day shift and one PSW on evening shift,
On identified date, the home was below the usual staffing compliment by two PSWs on day shift and one PSW on evening shift, and
On identified date, the home was below the usual staffing compliment by two PSWs on both day and evening shifts.
On identified date, the home was below the usual staffing compliment by two PSWs on day shift,
On identified date, the home was below the usual staffing compliment by one PSW on day shift and two PSWs on evening shift, and
On identified date, the home was below the usual staffing compliment by one PSW on day shift, with two PSWs working a short shift in the morning only and two PSWs on the evening shift.

Three residents, resident #005, resident #016, and resident #019, were randomly selected from both of the identified lists in the identified months to further review.

A) A review of the paper documentation and point of care (POC) records for

resident #005, identified baths were documented on three specified dates, and not again until a later specified date. In review of a calendar identified that one of the identified dates was in one week and the other fell in the following week, therefore identifying that resident #005, only received one bath in the identified week. In another month, resident #005 had a documented bath and the next documented bath was beyond a week, therefore only receiving one bath during that identified week again.

In an interview with DOC #104, they confirmed that during the identified two weeks, in two different identified months, resident #005 was only offered and provided one bath on each occasion. DOC #104 acknowledged that the reason resident #005 was not offered and provided the minimum two baths was due to short staffing.

The home failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

B) A review of the paper documentation and POC records for resident #016, identified baths were documented for seven dates between two months. The review indicated that resident #016 was provided one bath during an identified week.

In an interview, DOC #104 confirmed that resident #016 was only offered and provided one bath during the identified week, and the reasoning was due to the home being short staffed during an outbreak.

The home failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

C) A review of the paper documentation and POC records for resident #019, identified documented baths 11 baths in the identified three months. In review of the identified weeks, resident #019 was bathed once during two specified weeks.

In an interview, DOC #104 confirmed that resident #019 was only offered and provided one bath during the identified weeks. DOC #104 indicated that the

home was in outbreak and short staffed during both weeks identified.

The home failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) 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 nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the nutrition care and hydration programs included: the implementation of policies and procedures related to nutrition care and dietary services and hydration and the identification of any risks related to nutrition care and dietary services and hydration.

The home had developed policies that identified a system for documenting the food and fluid intake of residents at nutrition and hydration risk, however, the policies had not been implemented by staff.

Policy NDM-III-114, “Meal Service – Pleasurable Dining,” date noted, directed PSW or nursing staff to document all resident food and fluids consumed in the Point of Care Tasks. Food and fluid intake records, under the Point of Care Tasks, for two identified months were incomplete and staff had not recorded food and fluid intake for residents at nutrition and hydration risk.

During an interview with Registered Dietitian #125 on two specified date, they confirmed that there were large gaps in the food and fluid intake documentation,

resulting in lack of information for nutritional assessments and for the evaluation of the effectiveness of nutritional interventions.

The nutrition and hydration program at the home was unable to identify risks related to nutrition and hydration and did not allow for the evaluation of food and fluid intake of residents with identified risks related to nutrition and hydration.

Nutrition and hydration risks observed by Inspector #107 in the dining room or at snack service were not identified in food and fluid intake documentation, progress notes, or through referrals to the Registered Dietitian.

Examples where the home's program for nutrition care and hydration did not include the implementation of policies and procedures and identification of risks related to nutrition care and dietary services and hydration included:

A) Resident #008 was identified at high nutrition risk and had a documented weight loss below their goal weight range in an identified month. The resident was observed at the a specified date, lunch meal. Staff assisted the resident with their fluids and dessert at the meal. After one sip of fluids the resident began coughing and the resident did not take any additional fluids at the meal. Food and fluid intake records for the identified date, were not completed for the lunch meal. The resident's poor intake of fluids was not recorded.

The resident had a plan of care that directed staff to provide an identified food item at an identified snack pass. On five out of six days reviewed between an identified time period, prior to a nutrition assessment, the resident's identified snack intake records reflected not applicable, or the information was incomplete, resulting in the inability to evaluate the effectiveness of the strategy from the available documentation.

B) Resident #035 was identified at high nutrition risk with significant weight loss. Inspector #107 observed the resident at the lunch meal and an identified snack pass on an identified date. The resident did not consume their full meal or fluids at the lunch meal, required more assistance than was provided, and the resident did not consume a beverage or snack at the identified snack pass. Documentation on the resident's food and fluid intake records were blank for the identified date (no records for the whole day), and documentation in the progress notes did not identify the poor intake that day or that additional assistance was required.

Documentation on the resident's food and fluid intake records was incomplete with 32% of meals and 44% of snacks not recorded for an identified month, effecting the evaluation of the resident's nutrition and hydration.

C) Resident #032 was identified at high nutrition risk with an unintended weight loss over three months. The resident was significantly underweight with a noted low body mass index in a specified month. At the lunch meal on an identified date, the resident was significantly coughing while being assisted with drinking their fluids and the fluids were removed from the resident for the rest of the meal. PSW #112 stated they were going to get a dietary referral to Registered Dietitian #125 for further assessment, however, documentation in the resident's clinical health record between two identified dates, did not include mention of the coughing/choking while drinking fluids, poor intake of fluids at the meal, or mention of a referral to the Registered Dietitian for further assessment. During interview with Inspector #107, the Registered Dietitian stated that staff had mentioned something briefly but confirmed that there was nothing documented to identify the nutritional concerns and no referral to the Registered Dietitian was completed.

Documentation on the resident's food and fluid intake records was incomplete with 28% of meals and 39% of snacks not recorded for an identified month, effecting the evaluation of the resident's nutrition and hydration. Documentation of the resident's hydration for an identified two week period, reflected intake less than their fluid requirement, and less than 75% of their fluid requirement, however, documentation was incomplete and it was unclear what the resident's actual hydration pattern was. Concerns could not be accurately identified from the documentation available.

D) Resident #036 was observed at an identified snack pass on a specified date. The resident's snack was placed out of reach on the resident's bedside table and staff did not return to assist the resident with their snack. The resident did not consume a beverage or a snack at the snack service. The resident identified to Inspector #107 that they were hungry and thirsty prior to the supper meal and stated that they were not usually offered a snack in the afternoon. Documentation of the specified snack for the identified date, was not completed.

Documentation on the resident's food and fluid intake was incomplete with 45% of snacks not recorded for an identified month, effecting the evaluation of the

resident's intake and hydration level, including the provision of snacks.

E) Resident #030 was identified at high nutrition risk. At the identified date, lunch meal, the resident required more assistance than was provided to the resident. Documentation reflected the resident refused the lunch meal. At the observed afternoon snack pass on the identified date, the resident did not consume their pureed snack. The resident refused an evening snack. Food and fluid intake records were incomplete for the afternoon and evening snack pass.

Documentation of the resident's food and fluid intake records was incomplete with 26% of meals and 49% of snacks not recorded for an identified two week period.

F) Resident #009 was identified at nutrition risk. The resident required thickened fluids and a pureed texture snack. At the identified date afternoon and evening snack pass the resident did not consume a snack or beverage. Documentation was incomplete for the afternoon and evening snack pass on the identified date.

Documentation of the resident's food and fluid intake records was incomplete with 24% of meals and 42% of snacks not recorded for an identified month.

G) Documentation for most of the residents reviewed was missing on five identified dates.

On an identified date, the home was below the usual staffing complement by two PSWs and an RPN on the day shift for the first floor, one PSW on days for the second floor, two PSWs for the afternoon shift on the first floor and one PSW for the afternoon shift on the second floor.
On another identified date, the home was below the usual staffing complement by one staff on the first and second floors for the day shift, one PSW for the first floor and two PSWs for the second floor afternoon shift, and one PSW for the evening second floor shift.

On an identified date, the home was below the usual staffing complement by two PSWs on the first floor and second floor day shifts, one PSW for the afternoon shift on the first and second floors.

On an identified date, the home was below the usual staffing complement by one PSW on the first floor day shift, one PSW on the second floor afternoon shift.

On an identified date, the home was below the usual staffing complement by one PSW on the first floor day shift, and one PSW on the first floor afternoon shift.

During interview with Inspector #107, PSW #147 stated they were unable to get all the documentation completed when staffing was below the usual complement.

H) Nutrition Manager #120 provided policies to Inspector #107 related to the preparation and provision of thickened fluids and dysphagia management. The policies did not contain a policy number, title, or date of implementation. The Nutrition Manager confirmed that the policies had not yet been implemented and did not provide implemented policies to the Inspector.

I) Not all staff were consistent in the way they documented fluids consumed for an identified program. The Point of Care Task identified that residents were to be offered additional fluids to residents every two hours.

During interview with Inspector #107, PSW #107 stated that the fluids times and the identified program times often corresponded (breakfast at 0800 hours, morning snack 1000 hours, lunch at 1200 hours, afternoon snack 1400 hours, 1800 hours supper, evening snack 2000 hours) so the PSW recorded the fluids taken at meals and documented the same fluids taken in the identified program record. This would result in a duplication of a resident's intake, resulting in the resident appearing to consume more fluids than they did. During interview with Inspector #107, the Director of Care (DOC) #104 confirmed that staff were to record each beverage only once. Staff, including the Registered Dietitian, would not be able to accurately evaluate a resident's hydration status.

The home's nutrition care and hydration policy related to documentation of food and fluid intake and dysphagia management were not implemented and the program did not allow for the identification and management of risks related to nutrition and dietary services and hydration, with a system that enabled the evaluation of nutrition and hydration intake of residents.

(107)

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times.

A complaint was submitted to the Director, related to 24 hour nursing care.

Ontario Regulation 79/10, section 45, outlines exceptions for the requirement of one registered nurse on duty and present at all times, for homes with a licensed bed capacity of more than 64 beds and fewer than 129 beds, in the case of an emergency where the backup plan is met. A RN who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if, the director of nursing and personal care or a RN who is both an employee of the licensee and a member of the regular nursing staff is available by telephone, and a registered practical nurse who is both an employee of the licensee and a member of the regular nursing staff is on duty and present in the home.

Ontario Regulation 79/10 defines an emergency as an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long term care home.

Cedarwood Village would qualify for this exemption, in the case of an emergency, as the total number of beds in the home was 90.

The current planned staffing pattern for registered nursing staff, for the direct care of residents, included three Registered Nurse (RN)s working 8 hour shifts for a total of 24 hours per day and 5 Registered Practical Nurses (RPNs), two working 12 hour shifts and three working 8 hour shifts, for a total of 24 hours per day, as identified on work schedules provided by the home and confirmed by ward clerk #128.

The home's RN schedules for three identified months were reviewed and identified no RN coverage for eight identified shifts.

The Director of Care (DOC) # 104, confirmed that there were no RNs in the home on the identified dates and associated shifts.

In an interview with the Administrator #105, they confirmed that the need to fill these RN shifts were not the result of emergency situations as outlined above. Administrator #105 also confirmed that the home did not have back up plan for registered staff.

The home did not ensure that there was at least one registered nurse who was an employee of the licensee and was a member of the regular nursing staff on duty and present in the home at all times. [s. 8. (3)]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
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:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1.The licensee failed to ensure that resident #008 was assessed using a multidisciplinary approach and that actions were taken and outcomes evaluated for any weight change that compromised the resident's health status.

A) Resident #008 had a plan of care that identified a goal of weight maintenance within an identified goal weight range, revised in an identified month. The resident had a previous goal weight range, identified in the Weights and Vitals section of Point Click Care (PCC). The resident was identified at high nutritional risk.

The resident had a documented weight loss between two identified months and an identified weight loss over one year.

A concern was voiced to Inspector #107 by the resident's substitute decision maker about the resident's weight loss. The resident dropped below their revised goal weight range in a specified month. The RD #125 completed a quarterly review on an identified date, and identified the resident's specified month's weight had not been entered into the PCC computerized system. The plan was to continue with current interventions. Inspector #107 identified that the weight was recorded on the bath sheet for the identified month (unclear what date the weight was taken), however, the weight had not been entered into the computer system by the nursing department.

A weight warning was triggered for weight loss in an identified month. The RD

#125 reviewed the weight warning on a specified date, and identified the change was not a significant change (not significant over two months) and the plan was to continue the current plan and continue to monitor weight. During interview with Inspector #107, RD #125 confirmed that the resident and/or the resident's substitute decision maker were not consulted during the assessment process and the resident was not observed at meals or snacks in relation to the weight loss.

The resident had fallen below their goal weight range without revision to the nutritional strategies or revision to the resident's goal weight range. Action was not taken to address the weight loss below the resident's goal weight range.

B) Resident #011 had a plan of care that identified a goal for weight maintenance within a goal weight range and the resident was identified at nutritional risk.

The resident's weight fell below their goal weight range in an identified month, however, nutritional strategies to address the weight loss were not revised at the identified quarterly review. The resident lost an identified percentage of their body weight between when they fell below their goal weight range and when strategies were revised on an identified date. The resident lost an identified percentage of their body weight in one year.

A weight warning was triggered on an identified date, however, the nutritional plan of care was not revised and the plan was to continue to monitor the resident's weight and intake. Action was not taken to address the weight loss below the resident's goal weight range. The resident's plan of care was not revised until the quarterly review, completed on a specified date, after further weight loss. During interview with Inspector #107, Registered Dietitian #125 stated that due to previous concerns with the accuracy of the scales that strategies were not always initiated promptly as the Dietitian wanted to monitor for trends to see accuracy of the weight changes.

The resident's plan of care identified the resident frequently slept in through the breakfast meal. The RD #125 confirmed that they had not initiated a plan to address the frequently missed meal. The nutrition care plan identified that family requested an identified food item at the an identified snack, however, the plan had not been revised since an identified year. The resident's plan of care also included another intervention at an identified meal. This had not been re-evaluated in relation to the resident's preferences.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance the licensee shall ensure that residents with the the outlined weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #9: 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:
4. Monitoring of all residents during meals. 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:
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:
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. O. Reg. 79/10, s. 73 (1).

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 O. Reg. 79/10, s. 73 (2).

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 residents were monitored during meals.

The Home's policy "NDM-III-114, Meal Service – Pleasurable Dining ", with an identified date, stated that residents were to be attended by at least one staff member while in the dining room. During interview with Inspector #107, the Director of Care (DOC) #104 confirmed that at least one staff was required to be in the dining room while residents were eating and drinking.

At a number of observed meals services, on a specified dates and in identified dining rooms, residents were observed eating and drinking while staff were not in the dining rooms. Staff were observed transporting residents to their rooms or completing other duties outside the dining area while residents were still eating and drinking. Inspector #107 was in the dining room and observed that staff were not always within a visual or auditory range of the dining room

At the supper meal on an identified date, PSW #137 stated that they didn't want to rush the residents so they were leaving the residents alone to finish their meals. Resident #026 required assistance with eating and drinking and verbal prompting during the meal. Staff had left the dining room prior to the resident finishing their meal and were in and out of the dining room for extended periods. At an identified time, another PSW #121 came back to the dining room and assisted the resident to finish their meal and beverages.

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

On a specified date, trays for residents #012 and #014 were plated prior to when Inspector #107 entered the dining room at an identified time. Resident #014 received their tray at an identified time and resident #012 received their tray at another identified time. Staff had provided a cover for the entrees, however, a particular food item had not been covered. The home's policy, "NDM-III-115 Tray Service", with a noted date, directed staff to cover all items on the tray.

Staff did not heat the items prior to service to the residents. Resident #014 confirmed their meal was not very warm. With the permission of the resident, Inspector #107 probed the resident's soup at 78.1 degrees Fahrenheit (F). The resident left the soup mostly uneaten. The home's policy, "NDM-III-114 Meal Service – Pleasurable Dining", with a noted date, stated that meals were to be served to residents at a minimum of 60 degrees Celsius (140 degrees F). Resident #012 confirmed to Inspector #107 that their identified food was cold. Inspector #107 probed the resident's meal (with permission). The entree was probed at 79.4 degrees F. The resident stated it was cold.

Dietary staff left the dining room right after the last person in the dining room was served and trays were plated prior to the dietary staff leaving the dining room.

Tray service with hot foods, were routinely plated prior to delivery to residents and a particular food item was left uncovered for extended periods at two identified date lunch meals, prior to service to residents.

At the supper meal on an identified date, entrees for tray service were observed being heated prior to service, however, PSW #121, who heated the trays, stated that direction related to length of heating was not provided. The PSW did not probe the food again prior to service to ensure temperatures were safe and palatable.

3. The licensee failed to ensure that residents were provided with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

Not all residents received the required assistance with the lunch meal and the afternoon snack service on an identified date.

a. The plan of care for resident #035 identified that they required extensive assistance and supervision with eating. The resident was identified at high nutrition risk with significant weight loss.

Inspector #107 observed the resident at the lunch meal and afternoon snack pass on the identified date. At the lunch meal the resident sat without consuming their beverages or dessert for an extended period (more than 15 minutes) and the resident's apron was removed. When Inspector #107 asked the resident about their beverages and dessert the resident stated they would take some but required assistance. When PSW #112 was asked by Inspector #107 to provide assistance, the resident consumed additional food and fluids.

At the observed snack service, a sealed snack and a glass of water were left on a bedside table for the resident #035 at an identified time. Inspector #107 remained on the unit and Inspector #107 did not observe staff returning to the resident's room to assist the resident with their snack. At 1630 hours, the resident's snack remained untouched and was in the same spot as when it was dropped off for the resident at 1440 hours. When asked by Inspector #107, the resident confirmed they required assistance with the snack. Inspector #107 asked the resident if staff came to assist the resident with their snack and the resident confirmed that they

had not been offered assistance with their afternoon snack. Inspector #107 asked the resident if they would like a beverage and the resident replied that they would. When Inspector #107 asked if the resident would like their snack the resident stated they would try it. Inspector #107 informed PSW #130 who then went to assist the resident just prior to the dinner meal. The PSW stated the resident took some sips of water and the PSW brought the resident's cup of water to the dining room for the supper meal. The snack remained unopened.

b. The plan of care for resident #036 identified the resident required an assistive device for transfers in and out of bed as the resident was unable to consistently hold themselves up in an unsupported sitting position on the edge of the bed. The plan of care also identified that the resident required set up assistance for eating.

At an approximate time, a pureed snack and drink were left on a bedside table that was not within reach of resident #036. The resident was sleeping when the snack was left at the bedside and staff did not return to the resident's room prior to getting the resident up for the dinner meal at an identified time. The resident was awake when observed by Inspector #107 at an identified time. Inspector #107 asked the resident if they had been offered a snack or beverage and the resident stated they had not been. The resident stated they were hungry and thirsty when asked by the Inspector and stated that they were not usually offered a snack in the afternoon. The untouched snack remained at the bedside when the resident was taken to the supper meal.

c. The plan of care for resident #030 identified the resident was at high nutritional risk. At the observed lunch meal on an identified date, the resident repeatedly attempted to drink their glass of thickened beverage. The resident was unable to tip the glass up to get the last 1/3 of the beverage from the glass. The resident would pick up the glass, attempt to drink and then put down the glass several times without successfully drinking the rest of the beverage. Staff assistance was not provided. The resident had another beverage sitting on the table in-front of them, however, the second beverage had not been thickened. PSW #112 noticed the water was not thickened at an identified time and the resident was able to drink some of the beverage at the end of the meal service. The home's policy for thickened fluids that was provided to Inspector #107 stated that all beverages at the table were to be thickened at the same time when placed on the table for residents to ensure the safety of the resident. The resident had not been assisted with thickening the beverage for almost one hour.

The resident sat with their dessert in-front of them and assistance was not offered to the resident. The resident did not have a spoon at their place setting when the dessert was placed on the table. Inspector #107 requested a spoon for the resident at an identified time and the resident was assisted with their dessert ten minutes later.

d. The plan of care for resident #030 directed staff to provide a pureed texture snack for the resident. Staff delivering an identified date, afternoon snack cart ran out of bowls for the pureed snack so the resident's snack was placed in a 125 millilitre plastic cup (difficult to maneuvre a spoon into the small opening and deep cup). A thickened beverage was placed in the resident's hand with a straw, however, the pureed snack was placed on a table in the resident's room. The resident was unable to reach the table and did not consume the snack. Staff did not return to the room to assist the resident with their pureed snack and the snack remained uneaten on their table until it was collected by staff at the evening snack pass.

e. At the observed lunch meal on an identified date, resident #031 took a used napkin and straw from resident #032 and put the straw into their dessert which the resident had not completed. PSW staff #107 that was assisting at the table had left the table to provide assistance to another resident and no staff were assisting at the table. Resident #031's dessert and plates were removed when staff returned to the table without further assistance being offered.

f. Resident #011 was identified at nutrition risk and the resident had unplanned weight loss below their goal weight range. The resident's plan of care directed staff to provide place fluids into the resident's hands, cue the resident to drink to promote consumption.

At an observed lunch meal on an identified date, resident #011 had an assistive device in their hand, which was not being used as directed. The resident was unable to manuevre the assistive device, limiting their ability to intake. PSW staff were in and out of the dining room and were not assisting the resident with their beverages. PSW #100 did eventually come to assisted the resident.

At an observed supper meal on an identified date, Inspector #107 observed the resident having difficult with their meal. A good portion of the resident's meal and dessert had spilled onto the resident's lap.

Documentation in the resident's progress notes and interview with the Registered Dietitian #125 reflected the resident was not receiving the required level of assistance with eating at meals and snacks due to an outbreak situation where staff were unavailable to provide the level of assistance with eating the resident required, resulting in weight loss.

The home was below the planned staffing complement for PSW staff on both the morning and afternoon shift for the first floor on the identified date.

4. The licensee failed to ensure that no person simultaneously assisted more than two residents who need total assistance with eating or drinking.

Complaints were submitted to the Director on four identified dates between two identified months, all including concerns regarding staffing.

On an identified date, the daily assignment sheet, which outlined staffing for the day, indicated that the floor was short two personal support worker (PSW), leaving three PSWs for the evening shift. The full complement of staff for the evening shift on second floor was five PSWs. The second floor has three dining rooms, each with approximately 12 residents. Dining room 5 has the greatest number of residents requiring assistance.

During an observation of a supper meal service on the identified date, in dining room 5 on the second floor, inspector #750 witnessed PSW #134 simultaneously assisting residents #004, 021, 022, 023 and 024, who were set at two separate tables, while also clearing plates, serving dessert, cuing and assisting other residents in the dining room. PSW #134 was the only staff in addition to the dietary aid, who was serving residents meals and left the dining room as soon as all resident's had received their meals, in the dining room during the observation.

In an interview with PSW #134, they confirmed that when the home is short staffed and there are only three PSWs working, there are three dining rooms on the floor, which need each PSW to attend a dining room. PSW #134 acknowledged that when there is only one staff in each dining room, that requires assisting multiple residents at one time with eating and drinking. PSW #134 confirmed that due to being short staff on the identified date, during the supper meal they had to assist more than two residents at one time.

A review of the observed resident's assistance requirements found all of the observed residents required some level of assistance with eating.

The home failed to ensure that no person simultaneously assisted more than two residents who need total assistance with eating or drinking.

5. The licensee failed to ensure that resident #009, who required assistance with eating or drinking, was not served a meal until someone was available to provide the assistance required by the resident.

At the observed lunch meal on an identified date, resident #009 was sitting at the table with their food in-front of them, prior to 1220 hours when Inspector #107 came to the dining room. The meal was untouched by the resident. PSW #131 sat down to assist the resident with eating at approximately 1235 hours and the resident ate their meal. The PSW confirmed that the resident required assistance with eating at the meal.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance the licensee shall ensure that the home has a dining and snack service that includes, at a minimum, monitoring of all residents during meals, food and fluid being served at a temperature that is both safe and palatable to the residents and providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1.
The licensee failed to ensure that drugs were stored in a medication cart that was secure and locked on a specified date.

At 1200 hours on the specified date, a medication cart was observed unlocked and unattended in the doorway of a resident's room. Inspector #107 was able to access the cart. RPN #110 was at the nursing station down the hall without visual sight line on the medication cart. A resident was also in the hallway just up from the medication cart.

When RPN #110 returned to the cart they confirmed that the cart was left unlocked and should have been locked when unattended. [s. 129. (1) (a) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance the licensee shall ensure that drugs are stored in an area or medication cart that is secure and locked, to be implemented voluntarily.

WN #11: 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. (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 failed to ensure that all staff participated in the implementation of the infection prevention and control program.

a. On an identified date, PSW #107 entered resident #010's room without wearing Personal Protective Equipment. The resident was in their room and had interaction with the PSW. The resident had a sign on the door that indicated that particular precautions were required. When the PSW left the room they confirmed to Inspector #107 that they were supposed to wear personal protective equipment but had not done so.

b. On an identified date, PSW #124 was in resident #013's room, conversing with the resident for an extended time, touching surfaces in the room, and clearing the residents meal tray without wearing personal protective equipment. The resident had a sign on the door identified particular precautions were required. The PSW stated that they were supposed to wear an identified item of personal protective equipment , however, they forgot that the precautions were required.

c. On an identified date, staff #123 provided a snack to resident #013 in their room and did not wear personal protective equipment. The resident had a sign that identified that particular precautions were required. Staff member #123 was within two (2) meters of the resident in their room.

d. At the afternoon snack service on an identified date, PSW #130 was observed clearing dirty dishes and then delivering food without sanitizing their hands. Inspector #107 asked PSW #130 to sanitize their hands prior to continuing the snack cart. The PSW was also observed refilling personal water bottles without changing gloves or sanitizing their hands between tasks.

e. Multiple staff delivering tray service did not ensure that food and fluids being transported through the hallways were covered to prevent contamination. The home's policy, "NDM-III-115 Tray Service", with an identified date, directed staff to cover all items on the tray. During interview with the Nutrition Manager #120 on an identified date, they confirmed that all items for tray service were to be covered with plastic covers, domes, or saran wrap.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance the home shall ensure that the infection prevention and control program required under subsection 86(1) of the Act complies with the requirements of this section, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 234. Staff records

Specifically failed to comply with the following:

s. 234. (4) The licensee is only required to ensure that the record under subsection (1) includes the matters set out in paragraphs 2, 3 and 4 of that subsection with respect to a staff member who falls under clause (c) of the definition of "staff" in subsection 2 (1) of the Act and,
(a) who will provide direct care to residents; or O. Reg. 79/10, s. 234 (4).
(b) who does not fall under clauses (2) (a) and (b) of this section. O. Reg. 79/10, s. 234 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a record was kept for each staff member, as defined as a pursuant to a contract or agreement between the licensee and an employment agency or other third party, of the home who provides direct care to residents, including the staff member's qualifications, previous employment and other relevant experience, a verification of the staff member's current certificate of registrations with the college of the regulated health professional of which he or she is a member, or verification of the staff member's current registration with the regulatory body governing his or her profession, the staff member's criminal reference check under subsection 75(2) of the Act and the staff member's declarations under subsection 215(4).

Upon identification by the DOC #104 that the home did not provide training to the agency staff providing direct care to residents in the home, it was confirmed that the licensee did not keep records for each staff member employed through an agency that included their qualifications, previous employment, experience and their police record checks by the DOC on an identified date. [s. 234. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance the licensee shall ensure that the record under subsection (1) includes the matters set out in paragraphs 2, 3, and 4 of that subsection with respect to a staff member who falls under clause (c) of the definition of "staff" in subsection 2 (1) of the Act and who will provide direct care to residents; or who does not fall under clause (2) (a) and (b) of this section, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

1.The licensee failed to ensure that each resident of the home received preventative and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

A review of resident #007's clinical record identified that resident was to receive external foot care services as indicated in their care plan with an initiated date identified. A progress note from a specified date, recorded that foot care services were provided by the external foot care service provider.

During an observation on an identified date, resident #007's toenails were found to be long; resident #007 could not recall when they would have been trimmed last.

In an interview with Resident Assessment Instrument (RAI) Coordinator #136, they confirmed that resident #007 had not been transferred over to the new external foot care provider and the last documented record of resident #007 receiving foot care was on a specified date, by PSW staff.

The home failed to ensure that resident #007 received preventative and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:
4. Strategies to maximize residents' independence, comfort and dignity, including equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 51 (1).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the continence care and bowel management program provided strategies to maximize residents' independence, comfort and dignity, including equipment, supplies, devices and assistive aids.

This is additional evidence to support non-compliance with existing compliance order not past-due from December 2019, Complaint Inspection 2019_546750_0017, CO #001, with a compliance due date of April 6, 2020.

The compliance order required the home to ensure that residents who required a hoyer lift were assessed by a member of a registered staff (i.e. registered nurse, physiotherapist, etc.) to determine their capability to be toileted on the toilet and to ensure that all residents and/or resident's substitute decision makers were given an opportunity to participate fully in the development and implementation of the residents' toileting plan.

Resident #002 was assessed as fully continent of bowels at the RAI-MDS quarterly review on a specified date. Progress notes did not identify that there were concerns related to the resident's continence between two identified dates. On an identified date, a progress note identified the resident was to use the hoyer lift for transfers and as per the home's new policy the resident would no longer be toileted.

Bowel records for two specified months, identified the resident was mostly continent of bowels, until the implementation of the identified policy, and resident was mostly incontinent.

Resident #002 had a plan of care that included a communication focus with associated strategies. The plan was initiated a specified date, and revised on another identified date.

On two identified dates, Physiotherapist (PT) #108 attempted to conduct an identified test on the resident, however, stated they were unable to complete the test due to the resident not following directions.

During interview with Inspector #107, PT #108 confirmed that they did not use the communication strategies identified in the resident's plan of care. A re-assessment of the resident's ability to be toileted had not occurred since an identified date, using the identified techniques outlined in resident's plan of care and involving the resident's substitute decision maker.

The PT #108 repeated the assessment on a later date, using the strategies identified in the resident's plan of care and including the resident's substitute decision maker, and the resident was able to pass the identified test. The PT #108 also conducted a trial with an assistive device the same day and the resident was deemed capable using the assistive device.

Resident #002 was required to use their incontinence product and was not permitted to use the toilet or to use a bed pan during the period between two identified months. The resident developed associated skin breakdown during the time their continence plan changed.

During interview with RN #106 and PSW #107 they stated that the resident did not have skin breakdown prior to the change to their continence care plan.

During interviews with the resident's Substitute Decision Maker (SDM), they voiced concerns to Inspector #107 that the resident's continence care changed over a three month period and resulted in skin impairment.

2. The licensee failed to ensure that resident #034, who was unable to toilet independently, received assistance from staff to manage and maintain their

continence.

The plan of care for resident #034 directed staff to assist the resident as per an identified toileting schedule, and as needed. The plan was in place since a specified date, with a goal to prevent skin breakdown through to the next review date.

On an identified date, the resident was scheduled for an appointment outside of the long-term care home after the an identified meal. The resident's substitute decision maker voiced a complaint to Inspector #107, that the resident was not provided assistance with continence care as per their toileting schedule.

Personal Support Worker (PSW) #107, who provided care to the resident on the identified date, confirmed that the resident had a toileting plan and that they were aware that the resident was going to the appointment on the identified day. The PSW stated that due to delays in meal service, staff were unavailable to provide care to the resident as per their toileting schedule. The PSW confirmed that continence care was not provided to the resident as per the resident's schedule and prior to the appointment on the identified date.

In an identified month, the resident was documented to have skin impairment related to continence care.

The home was below the usual staffing complement by one PSW on the day shift on the identified date for the first floor.

Issued on this 30th day of July, 2020 (A1)

[redacted]

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 STACEY GUTHRIE (750) - (A1)
Inspection No. / No de l'inspection :	2020_837750_0005 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	000376-20, 001127-20, 002054-20, 003293-20 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 30, 2020(A1)
Licensee / Titulaire de permis :	Maplewood Nursing Home Limited 73 Bidwell Street, TILLSONBURG, ON, N4G-3T8
LTC Home / Foyer de SLD :	Cedarwood Village 500 Queensway West, SIMCOE, ON, N3Y-4R4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Marci Hutchinson

To Maplewood Nursing Home Limited, 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 :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee must be compliant with Long Term Care Homes Act, 2007 s. 6 (1) (c).

Specifically, the licensee must:
1. Ensure that Point of Care (POC) tasks related to foot care provide clear direction for staff;
2. Ensure staff are made aware of the updated list of residents who are receiving external foot care services;
3. Provide education to all staff who provide foot care to residents outlining the home's expectations and each disciplines role and responsibility.
4. Maintain records of training material used to educate staff, the dates training was provided and staff attendance.

Grounds / Motifs :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out clear direction regarding foot care to staff and others who provide direct care to the resident.

A complaint was submitted to the Director on a specified date, regarding concerns about resident #001's personal hygiene including foot care. The complainant noted that the home had a change with the external foot care provider in an identified month and during the transition period, resident #001 did not receive foot care.

A) A review of resident #001's written plan of care found an intervention indicating that foot care was to be completed by external provider, with an initiated date noted.

In the Point of Care (POC) tasks, for bathing, there was a question noted for all residents regarding foot care that was contradicting.

In an interview with Personal Support Worker (PSW) #100, they confirmed that there was a change with the external provider in an identified month and there was a delay with the new provider initiating services in the home. PSW #100 confirmed that they will perform foot care to residents on their identified bath day if required including resident #001, even if they are identified as receiving external services. PSW #100 also acknowledged that they will document yes to the POC question noted above even when the task was not performed, as that was the direction provided by management.

The Director of Care (DOC) #104 provided a piece of paper with a note from Point Click Care (PCC), with an identified date, from the administrator regarding resident's foot care, which was contradicting to the POC task noted above.

In an interview with DOC #104, they confirmed that there was a change in the home's external foot care provider in an identified month and due to outbreak and miscommunication, there was a delay in the new provider initiating the services in the home. DOC #104 confirmed that staff would not know to perform foot care to resident #001, when the external service provider was not available as it was documented in their plan of care to be completed by external provider. DOC #104 confirmed that the direction was unclear for staff.

The DOC #104 confirmed that any resident who was identified as having external foot care services would not have clear direction based on the conflicting information between the care plans and the POC task.

The home failed to ensure that there was a written plan of care for resident #001 that set out clear directions to staff and others who provide care to the resident.

Resident #006 and #007 were randomly selected as residents identified to receive external foot care services.

B) A review of resident #006's written plan of care noted that their foot care was to be provided by an external care provider, with an initiated date noted. An additional intervention for foot care to be provided by an external provider was initiated on a specified date.

In an interview with PSW #133, they explained that they assess any resident when they perform baths to see if they require foot care and will perform if necessary, including those identified on the list for external foot care. PSW #133 confirmed that they have in the past provided foot care for resident #006.

In an interview with RPN #135, they acknowledged that resident #006 was on the list for foot care services. RPN #135 noted that they had never provided footcare to any resident in the home and were not sure who the current provider was or when they were in the home.

In an interview with Administrator #105 and DOC #104 they acknowledged that the POC task was assigned to every resident, that the list of residents' receiving external foot care services was not updated or shared with staff and confirmed that clear direction was not provided to staff regarding residents' foot care in the home.

The home failed to ensure that there was a written plan of care for resident #006 that set out clear directions to staff and other who provide care.

C) A review of resident #007's written plan of care identified in their care plan that foot care was to be provided by an external provider, with an initiated date included and another intervention that noted foot care routinely provided by an external provider with an initiated date as well.

In an interview with PSW #100 and PSW #133, they acknowledged that they will provide footcare to residents if they need it including those who are on the list for external foot care services.

In an interview with Registered Practical Nurse (RPN) #135 and registered nurse (RN) #106 they both confirmed that there was a change in the foot care service provider in the home, that the posted list was out dated and they were not aware of the current residents who were receiving external foot care services in the home at

the time of the inspection.

In an interview with Administrator #105, they advised that the new external foot care service provider provides a list of the residents being seen during the dates the provider will be in the home via email. Administrator #105 noted that they believed residents on the list would not be getting their foot care completed by PSW staff. Administrator #105 acknowledged that the list was not being communicated with the staff identifying the new service providers list and corresponding schedule.

The DOC # 104 confirmed that staff were not given clear direction regarding resident #007's foot care.

The home failed to ensure that there was a written plan of care for resident #007 that set out clear directions to staff and other who provide care.

The severity of this issue was determined to be a level 2 as there was minimal discomfort to the residents. The scope of the issue was a level 3 as it was widespread. The home had a level 3 compliance history as there was on-going noncompliance with this subsection of the Act that included:

• VPC issued December 14, 2018 (2018_756583_0014);
• VPC issued July 12, 2017 (2017_574586_0012).

Additionally, the LTCH has a history of 24 other compliance orders in the last 36 months.
(750)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 06, 2020

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: 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Order / Ordre :

The licensee must be compliant with s. 11 (2) of the Long Term Care Homes Act.

Specifically, the licensee must:
1. Ensure that all food and fluids provided to residents are safe, including, but not limited to thickened fluids and pureed texture food.
2. Provide the required measuring spoons and clear directions for staff to follow for thickening beverages to the required consistency at all meals and on the snack carts.
3. Develop and implement a policy related to thickening and providing thickened fluids.
4. Educate all staff that would prepare or provide thickened fluids on the policy, type of thickening product being used, quantities to use, tools to measure the thickener, proper techniques to use to mix the thickener, amount of time the product is required to sit prior to providing to the residents, and techniques and procedures required for thickened nutritional supplements.
5. Document and maintain attendance records from the education provided.
6. Maintain records of the training material content used to train staff in the identified areas.
7. Develop a system to audit and monitor that thickened fluids are being prepared per the home's procedures and that residents on thickened fluids are provided a fluid consistency that is safe and based on their assessed needs. Complete the audits at a schedule of the home's choosing.

Document the outcome of each audit, and revise the processes, as necessary, based on the results of the audits.
8. Review the current food production methods, equipment, and recipes to ensure that staff are able to prepare pureed foods to the correct consistency.
9. Educate dietary staff, including Cooks, on the correct consistency of pureed foods, action to take if food is observed at a different consistency, and any communication methods for reporting back to the Nutrition Manager.
10. Develop a system to audit and monitor that pureed texture foods are being prepared per the home's procedures and that residents requiring pureed menus are provided a consistency that is safe and based on their assessed needs.
11. Implement a schedule for the required monitoring at the discretion of the home's choosing. Keep a documented record of all monitoring, including dates, outcome, action taken. Revise the processes, as necessary, based on the results of the audits.

Grounds / Motifs :

1. 1. The licensee failed to ensure that residents were provided with food and fluids that were safe, nutritious, and varied.

A) Fluids served to residents were not always safe and were not consistent with the residents' required diet order.

Direction for thickening beverages was included on the containers of thickener provided in each dining room, however, plastic containers of thickener in the dining rooms and containers on the snack carts did not include directions for staff on the quantity of thickener to provide for the desired thickness.

Multiple staff providing thickened beverages to residents throughout the inspection stated to Inspectors #107 and #750 that they were unclear on the required amount of thickener to be added to beverages and unclear on the size of cups, specifically adaptive devices, that were provided to residents.

a. At the lunch meal on an identified date, staff # 114 did not know how much thickener to add to resident #022's beverages. The staff were using a large plastic container of thickener and plastic spoons to portion the thickener and directions were not included on the container.

b. At the lunch meal on an identified date, PSW #127 stated they were guessing on the amount of thickener for resident #025. PSW #127 and PSW #126 were unclear the size of each assistive device cup. Directions provided on the can of thickener identified the required amount of thickener for certain size cups.

c. At the afternoon snack pass on an identified date, staff #123 stated they were unsure on how much thickener to add to resident beverages. There was no direction provided for staff on the container of thickener or anywhere on the snack cart related to thickening fluids. A measuring spoon was not available on the snack cart and staff were observed using a plastic disposable spoon for portioning the thickener. Resident #004 and resident #025 both required the same consistency thickened fluids, however, PSW #129 added 1 plastic spoonful of thickener and PSW #121 added 3 large metal teaspoons.

d. At the lunch meal on an identified date, staff #114 staff did not use a measuring spoon for thickening the beverages for resident #009. The staff followed the directions on the container of thickener for number of scoops of thickener, however, staff used a disposable plastic spoon to portion the thickener, which was a different quantity than the measuring spoon inside the can of thickener.

e. Resident #009 required thick consistency fluids. The resident had a Physician's order for a nutritional supplement, to be provided twice daily, and thickened to the required consistency.

At the lunch meal on an identified date, RPN #119 confirmed that the supplement provided to resident #009 was not thickened and was not the required consistency identified in the resident's plan of care. Directions on the package of thickener identified that supplements required 15-20 minutes to thicken to reach the desired consistency. During interview with Inspector #107, the Nutrition Manager #120 stated that they had not discussed this issue with the nursing department to ensure that adequate time was available for thickening the product.

f. At the observed afternoon snack pass on an identified date, resident #009 was served a beverage that was thinner than the consistency identified in their plan of care. PSW #130 who prepared the beverage stated that the resident had been stating that their beverages were too thick so they thickened it less. Consultation with

Registered staff did not occur prior to providing the beverage that was incorrectly thickened.

g. Not all fluids on the table for resident #030 were thickened. A glass of an identified beverage had been thickened, however, a second glass of an identified beverage was left un-thickened in-front of the resident until right at end of meal service. Staff did not ensure that all fluids portioned and placed in-front of the resident were safe for the resident to consume.

B) Residents requiring a pureed menu were served food and fluids that were unsafe and had reduced nutritive value.

The pureed salad at the lunch meal on an identified date, the afternoon pureed snack on another identified date, and the pureed entrée and pureed dessert at the lunch meal on a different date, were noted to be a thin consistency and running over the plates/bowls. Preparation of pureed texture items to the correct consistency ensures that nutritive value is maintained (not diluted with too much fluid), that food is safe for residents who have difficulty swallowing.

At the lunch meal on a specified date, PSW #146 stated to Inspector #107 that the pureed food was usually thicker.

At the lunch meal on a specified date, the Nutrition Manager #120 stated that they noticed that the food was too runny on an identified unit and additional thickener was added. In an identified dining room, staff did not add additional thickener prior to serving the items to residents. Resident #009, who required thickened fluids started coughing when they were assisted with eating the pureed dessert. The resident was unable to continue eating the dessert due to the coughing. Resident #030, who also required thickened fluids, started coughing when consuming the pureed dessert. The resident was also unable to continue eating the dessert due to coughing and the item was removed.

At the lunch meal an identified date, the pureed salad was not smooth and appeared a bit chunky. PSW #131 confirmed that the salad was a bit chunky but that the salad was difficult to puree.

C) Food served to residents requiring a pureed menu were not always varied. The

planned menu for the an identified date supper meal included a particular item for dessert. At the observed supper meal, a pureed option of the dessert was not available for the pureed texture menu. An alternate pureed dessert (the same item that was served at the prior lunch meal) was substituted and served to residents requiring a pureed menu.

During interview with Inspector #107 on a specified date, Dietary Aide #115, who prepared the dessert, confirmed that they used leftovers for the dessert. The Dietary Aide stated that insufficient dessert was available to prepare all textures so the leftover alternate dessert was used for the pureed dessert. The Dietary Aide did not document the substitution and it was not communicated to the Nutrition Manager #120 so they could adjust the food order. The food served to residents requiring a pureed texture menu was not as varied as on the planned menu.

D) The nutritive value of fluids offered at snacks was not maintained for residents at high risk for weight loss and those residents receiving nutritional supplementation for additional calories. Diet drink crystals were served to those residents at the observed evening snack pass on a specified date. During an interview with Inspector #107 on an identified date, Nutrition Manager #120 confirmed that only diet crystals were offered on the snack carts and were provided to residents at nutrition risk and those requiring nutritional supplementation.

The severity of this issue was determined to be a level 2 as there was minimal discomfort to the residents. The scope of the issue was a level 2 as it occurred in several locations, and the same residents were affected by repeated occurrences of the same deficient practice. The home had a level 3 compliance history as there was on-going noncompliance with this subsection of the Act that included:

Compliance Order (CO) served December 14, 2018 (2018_756583_0014), complied on June 13, 2019.

Additionally, the LTCH has a history of 24 other compliance orders in the last 36 months.
(107)

Sep 30, 2020

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 :

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Order # / No d'ordre: 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section. 2007, c. 8, s. 76. (1).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 76(1).

Specifically, the licensee must:
1. Develop training material for all agency staff (PSWs and Registered staff) based on O. Reg 79/10 s. 222 (1) (a).
2. Ensure all agency staff coming into the home receive the above training before performing their assigned service.
3. Maintain record of all agency staff trained, including dates the training was provided.

Grounds / Motifs :

1. 1. The licensee failed to ensure that all staff received training as required by this section.

The licensee failed to ensure that no person mentioned in subsection (1) performed their responsibilities before they received training in the areas mentioned below.

In accordance with O. Reg 79/10 s. 222 (1) (a), a licensee of a long-term care home is exempt from the requirements under section 76 of the Act with respect to persons who fall under clause (b) or (c) of the definition of "staff" in subsection 2 (1) of the Act.

LTCHA, 2007, s. 2 (1) defines staff as persons who work in the home, (c) pursuant to a contract or agreement between the licensee and an employment agency or other third party.

In accordance with O. Reg 79/10 s. 222 (2), the licensee shall ensure that the persons described in clauses (1) (a) to (c) are provided with information about the items listed in the following paragraphs:
1. The Residents' Bill of Rights,
2. The long term care home's policy to promote zero tolerance of abuse and neglect of residents,
3. The duty under section 24 to make mandatory reports,
4. The protectors afforded by section 26,
5. Fire prevention and safety,
6. Emergency and evacuation procedures, and
7. Infection prevention and control,
of subsection 76 (2) of the Act before providing their services.

The Director of Care (DOC) #104, reported that the home had no formal orientation, training package or related material and no method of training any of the agency staff coming into the home. The DOC confirmed that the home does call on three different agencies for both personal support workers (PSW) and registered practical nurses (RPN) when the home is unable to find staff to fill shortages; A Supreme Nursing and Home Care, Paramount Care Nursing Agency and Lifeguard Homecare.

In an interview with PSW #151, on a specified date, while they were working in the home, they confirmed that they did not receive any training when they came to the home. They described their orientation to involve another PSW showing them around the unit, going over what they were to do and advising where items that may be required were located on the unit. PSW #151 confirmed that they did not review any policies or complete any formal training regarding the outlined training requirements in the Long Term Care Homes (LTCH) Act. PSW#151 advised that they were a RPN student in school and worked for the agency during school breaks and holidays.

RPN #116, who was an employee of the home noted that they train all agency registered staff coming into the home by providing an overview of the home's medication system, noting that the home had recently changed pharmacy providers. RPN #116 explained that if an agency RPN has not been to the home before, some will come in an hour early to review the processes in the home. RPN #116 confirmed

that this was at the discretion of the agency staff, not expected or directed by the home.

In an interview with both Agency Manager #152 and #153, they confirmed that training was to be completed by the home requesting their staff. They did confirm that they complete criminal reference checks on their staff, and both noted that they recently received a request from DOC #104 for record of these criminal reference checks.

The Clinical Coordinator #149 acknowledged that all of the home's training is completed face to face and provided an outline of the areas covered in an excel document as well as a sample agenda for the general orientation. The clinical coordinator #149 explained they were working on the development of a training package for agency staff including the logistics of who would be providing the training and confirmed that the home did not have this in place at the time of the inspection.

The home failed to ensure that all agency staff working in the home received training in the areas mentioned above before they performed their responsibilities.

The severity of this issue was determined to be a level 2 as there was minimal discomfort to the residents. The scope of the issue was a level 3 as it was widespread. The home had a level 3 compliance history as there was on-going noncompliance with this subsection of the Act that included:
• Voluntary Plan of Correction issued on July 22, 2019, (2019_689586_0007);
• Compliance Order issued on December 14, 2018, (2018_756583_0014), complied on June 13, 2019;
• Voluntary Plan of Correction issued on December 14, 2018, (2018_756583_00140);

• Voluntary Plan of Correction issued on July 12, 2017, (2017_574586_0012).

Additionally, the LTCH has a history of 24 other compliance orders in the last 36 months.
(750)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 06, 2020

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

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

Order / Ordre :

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

The licensee must be compliant with O.Reg. 79/10, s. 31 (3).

Specifically, the licensee must:
1. Ensure that the staffing plan outlines the process of how staff shifts are scheduled, including the call-in process.
2. Ensure that the plan outlines the promotion of continuity of care by minimizing the number of different staff members who provide nursing and personal support service to each resident
3. Ensure the home has a back up plan for nursing and personal support workers that addresses situations when staff, including staff who must provide the nursing coverage required under subsection 8(3) of the Act, cannot come to work and that it is included in the staffing plan.
4. Ensure that the staffing plan is evaluated and updated at a minimum of annually.
5. Maintain evidence of any and all evaluations of the staffing plan.

Grounds / Motifs :

(A1)
1. The licensee failed to ensure that the home had a written staffing plan regarding the organized program of nursing and personal support services required under clause 8(1) (a) and (b) of the Long Term Care Act, and the staff plan must:

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

A complaint was submitted to the Director on an identified date, related to 24 hour nursing care. Additionally, three other complaints were submitted to the Director in two identified months, including concerns regarding staffing.

Cedarwood Village is a Long-Term Care Home (LTCH) with a licensed capacity of 90 beds, with 45 residents on the first floor and 45 residents on the second floor. The licensee used a "Daily Assignment Sheet" which had the following staff mix over a 24 hour (hr) period for Registered Nurses (RN), Registered Practical Nurses (RPN) and Personal Support Workers (PSW):
RN's - three staff per day, scheduled from 0600 to 1400 hrs, 1400 to 2200 hours and 2200 to 0600 hrs.
RPN's - First floor, two staff per day, scheduled from 0600 to 1400 hrs and 1400 to 2200 hrs.
- Second floor, two staff per day, scheduled from 0600 to 1800 hrs and 1800 to 0600 hrs.
(expect Fridays where three 8hr shifts of RPNs were scheduled)
PSW's - First and second floor each had 12 staff per day, five staff scheduled from 0600 to 1400 hrs, five staff from 1400 to 2200 hours and two staff from 2200 to 0600 hrs.

1. In interviews with the Administrator and Director of Care (DOC) it was confirmed that the identified staffing mix current, and it was the staffing mix in place at the time of the inspection that was required to meet the residents' assessed care and safety needs.

A. The planned staffing mix for RN's in the home, for the direct care of residents, was three Registered Nurses (RN) for a total of 24 hours per day, as identified on work schedules provided by the home and confirmed by the Ward Clerk.

During an interview with the DOC on an identified date, they confirmed the home did not have RN coverage for eight shifts between three identified months.

In an interview with the Administrator, they confirmed that the home did not have a documented process setting out the organization and scheduling of registered staff shifts. Additionally, the Administrator confirmed that the home did not have a written back up plan for nursing that addressed situations when staff, including those who must provide the nursing coverage required under subsection 8(3) of the Act, cannot come to work.

B. The planned staffing mix for RPNs in the home for direct care of residents, was two RPNs working on each floor (totaling four) on Saturday through Thursday, and on

Fridays each week, there should be three RPNs working on the second floor and two RPNs on the first floor (totaling five).

A review was conducted of the staffing levels on select dates in three identified months, as the complainants identified that staff shortages occurred during this time, noting two separate outbreaks that contributed additionally to staff shortages. The review identified seven incidents were the home was short at least one RPN during the identified months.

As noted above, in an interview with the Administrator on an identified date, they confirmed that the home did not have a written process to set out the organization and scheduling of registered staff shifts or a backup plan for nursing staff that addressed situations when staffing, including those who must provide the nursing coverage required under subsection 8(3) of the Act, cannot attend work.

C. The planned staffing mix for PSWs in the home for direct care of residents, was five PSWs working on each floor of the home on day and evening shifts (totaling ten), and two PSWs working on each floor on the night shift (totaling four).

A review was conducted of the staffing levels on select dates in three identified months, as the complainants identified that staff shortages occurred during this time, noting two separate outbreaks that contributed additionally to staff shortages.

It was identified through staffing records that there were 27 dates between three identified dates, where the home was short PSW shifts.

Interviews were conducted with PSWs #107 and #118, they confirmed PSW staff were often not able to meet all of the residents care needs as per the residents plan of care when the home had significant PSW shortages.

2. While inspecting the following resident care needs were noted and their actual and potential impacts to the care of residents were identified:

A. A review of the home's bathing records for three identified months, was completed. It revealed that all residents on the first floor missed their scheduled baths on the six identified dates.

During an interview with Quality Improvement, they confirmed that the scheduled baths on the identified dates were missed and not made up due to staff shortage.

B.
i) The Home's policy "NDM-III-114, Meal Service - Pleasurable Dining ", with an identified date, was reviewed and stated that residents were to be attended by at least one staff member while in the dining room.

At a number of observed meal services on identified dates, in identified Dining rooms, residents were observed eating and drinking while staff were not in the dining rooms. Staff were observed transporting residents to their rooms or completing other duties outside the dining area while residents were still eating and drinking. Inspector #107 was in the dining room and observed that staff were not always within a visual or auditory range of the dining room.

At the supper meal an identified date, PSW #137 stated that they didn't want to rush the residents so they were leaving the residents alone to finish their meals. Resident #026 required assistance with eating and drinking and verbal prompting during the meal. Staff had left the dining room prior to the resident finishing their meal and were in and out of the dining room for extended periods. At 1800 hours another PSW #121 came back to the dining room and assisted the resident to finish their meal and beverages.

During interview with Inspector #107 on an identified date, Director of Care (DOC) #104 confirmed that at least one staff was required to be in the dining room while residents were eating and drinking.

ii) On an identified date, the daily assignment sheet, which outlined staffing for the day, indicated that the floor was short two personal support worker (PSW), leaving three PSWs for the evening shift. The full complement of staff for the evening shift on an identified unit was five PSWs. On an identified unit there are three dining rooms, each with approximately 12 residents. Dining room 5 has the greatest number of residents requiring assistance.

During an observation of a supper meal service on an identified date, in dining room 5 on the second floor, inspector #750 witnessed PSW #134 simultaneously assisting

residents #004, 021, 022, 023 and 024, who were set at two separate tables, while also clearing plates, serving dessert, cuing and assisting other residents in the dining room. PSW #134 was the only staff in addition to the dietary aid, who was serving residents meals and left the dining room as soon as all resident's had received their meals, in the dining room during the observation.

A review of the observed resident's assistance requirements found resident #004 and resident #024 required one staff extensive assistance with eating, resident #022 required total assistance with eating, resident #021 required set up with observation, staff to feed part of meal when required and resident #023 required set up assistance and supervision with guidance to complete task including staff placing items into resident's hand.

In an interview with PSW #134, they confirmed that when the home is short staffed and there are only three PSWs working, there are three dining rooms on the floor, which need each PSW to attend a dining room. PSW #134 acknowledged that when there is only one staff in each dining room, that requires assisting multiple residents at one time with eating and drinking. PSW #134 confirmed that due to being short staff on the identified date, during the supper meal they had to assist more than two residents at one time.

iii) At an observed lunch meal on an identified date, resident #011 had an assistive device. The resident was unable to successfully use the noted assistive device. PSW staff were in and out of the dining room and were not assisting the resident. Eventually, PSW #100 then came and assisted the resident.

At an observed supper meal on an identified date, Inspector #107 observed the resident having difficult with their meal. A good portion of the resident's meal and dessert had spilled onto the resident's lap.

Resident #011 was identified at nutrition risk and the resident had unplanned weight loss below their goal weight range. The resident's plan of care directed staff to support resident with fluid and food consumption. Documentation in the resident's progress notes and interview with the Registered Dietitian #125 reflected the resident was not receiving the required level of assistance with eating at meals and snacks due to an outbreak situation where staff were unavailable to provide the level of assistance with eating the resident required, resulting in weight loss.

The home was below the planned staffing complement for PSW staff on both the morning and afternoon shift for the first floor on the identified date noted above.

iv) At the observed lunch meal an identified date, resident #031 used items used by resident #032, creating cross contamination. PSW staff#107 that was assisting at the table had left the table to help another resident and no staff were assisting at the table. Resident #031's dessert and plates were removed when staff returned to the table without further assistance being offered.

The plan of care for resident #030 directed staff to provide a pureed texture snack for the resident. Staff delivering the identified date, afternoon snack cart ran out of bowls for the pureed snack so the resident's snack was placed in a 125 millilitre plastic cup (difficult to maneuvre a spoon into the small opening and deep cup). A thickened beverage was placed in the resident's hand, however, the pureed snack was placed on a table in the resident's room. The resident was unable to reach the table and did not consume the snack. Staff did not return to the room to assist the resident with their pureed snack and the snack remained uneaten on their table until it was collected by staff at the evening snack pass.

The plan of care for resident #030 identified the resident was at high nutritional risk. At the observed lunch meal on an identified date, the resident repeatedly attempted to drink their glass of thickened beverage. The resident was unable to tip the glass up to get the last 1/3 of the beverage from the glass. The resident would pick up the glass, attempt to drink and then put down the glass several times without successfully drinking the rest of the beverage. Staff assistance was not provided. The resident had another beverage sitting on the table in-front of them, however, the second beverage had not been thickened. PSW #112 noticed a beverage was not thickened at 1258 hours and the resident was able to drink some of the beverage at the end of the meal service. The home's policy for thickened fluids that was provided to Inspector #107 stated that all beverages at the table were to be thickened at the same time when placed on the table for residents to ensure the safety of the resident. The resident had not been assisted with thickening the beverage for almost one hour.

The resident sat with their dessert in-front of them and assistance was not offered to the resident. The resident did not have a spoon at their place setting when the

dessert was placed on the table. Inspector #107 requested a spoon for the resident at 1258 hours and the resident was assisted with their dessert ten minutes later.

The home was below the planned staffing complement for PSW staff on both the morning and afternoon shift for the first floor on an identified date.

v) On an identified date, at approximately 1450 hours, a pureed snack and drink were left on a bedside table that was not within reach of resident #036. The resident was sleeping when the snack was left at the bedside and staff did not return to the resident's room prior to getting the resident up for the dinner meal at 1650 hours. The resident was awake when observed by Inspector #107 at 1635 hours. Inspector #107 asked the resident if they had been offered a snack or beverage and the resident stated they had not been. The resident stated they were hungry and thirsty when asked by the Inspector and stated that they were not usually offered a snack in the afternoon. The untouched snack remained at the bedside when the resident was taken to the supper meal.

The plan of care for resident #036 identified the resident required set up assistance for eating.

The home was below the planned staffing complement for PSW staff on both the morning and afternoon shift for the first floor on the identified date.

vi) Inspector #107 observed resident #035 at the lunch meal and afternoon snack pass on an identified date. At the lunch meal the resident sat without consuming their beverages or dessert for an extended period (more than 15 minutes) and the resident's apron was removed. When Inspector #107 asked the resident about their beverages and dessert the resident stated they would take some but required assistance. When PSW #112 was asked by Inspector #107 to provide assistance, the resident consumed additional food and fluids.

At the observed snack service, a sealed snack and a glass of water were left on a bedside table for the resident #035 at 1440 hours. Inspector #107 remained on the unit and Inspector #107 did not observe staff returning to the resident's room to assist the resident with their snack. At 1630 hours, the resident's snack remained untouched and was in the same spot as when it was dropped off for the resident at 1440 hours. When asked by Inspector #107, the resident confirmed they required

assistance with the snack. Inspector #107 asked the resident if staff came to assist the resident with their snack and the resident confirmed that they had not been offered assistance with their afternoon snack. Inspector #107 asked the resident if they would like a beverage and the resident replied, "that would be nice". When Inspector #107 asked if the resident would like their snack the resident stated they would try it. Inspector #107 informed PSW #130 who then went to assist the resident just prior to the dinner meal. The PSW stated the resident took some sips of water and the PSW brought the resident's cup of water to the dining room for the supper meal. The snack remained unopened.

The home was below the planned staffing complement for PSW staff on both the morning and afternoon shift for the first floor on the identified date.

C. During an interview with Registered Dietitian #125 on two specified dates, they confirmed that there were large gaps in the food and fluid intake documentation, resulting in lack of information for nutritional assessments and for the evaluation of the effectiveness of nutritional interventions. The nutrition and hydration program at the home was unable to identify risks related to nutrition and hydration and did not allow for the evaluation of food and fluid intake of residents with identified risks related to nutrition and hydration.

Nutrition and hydration risks observed by Inspector #107 in the dining room or at snack service were not identified in food and fluid intake documentation, progress notes, or through referrals to the Registered Dietitian.

i) Resident 008 had a plan of care that directed staff to provide an identified food item at an identified snack pass. On five out of six days reviewed between two identified dates, prior to a nutrition assessment, the resident's identified snack intake records reflected not applicable, or the information was incomplete, resulting in the inability to evaluate the effectiveness of the strategy from the available documentation.

ii) Documentation on resident #035's food and fluid intake records was incomplete with 32% of meals and 44% of snacks not recorded for an identified month, effecting the evaluation of the resident's nutrition and hydration.

iii) Documentation on the resident #032's food and fluid intake records was incomplete with 28% of meals and 39% of snacks not recorded for an identified month, effecting the evaluation of the resident's nutrition and hydration. Documentation of the resident's hydration for an identified two weeks, reflected intake less than their fluid requirement on 24/32 days, and less than 75% of their fluid requirement on 19/32 days, however, documentation was incomplete and it was unclear what the resident's actual hydration pattern was. Concerns could not be accurately identified from the documentation available.

iv) Documentation on the resident #036's food and fluid intake was incomplete with 45% of snacks not recorded for an identified month, effecting the evaluation of the resident's intake and hydration level, including the provision of snacks.

v) Documentation of the resident #30's food and fluid intake records was incomplete with 26% of meals and 49% of snacks not recorded for an identified two week period.

vi) Documentation of the resident #009's food and fluid intake records was incomplete with 24% of meals and 42% of snacks not recorded for an identified month.

Documentation for most of the residents reviewed was missing on five identified dates.

On an identified date, the home was below the usual staffing complement by two PSWs and an RPN on the day shift for the first floor, one PSW on days for the second floor, two PSWs for the afternoon shift on the first floor and one PSW for the afternoon shift on the second floor.
On an identified date, the home was below the usual staffing complement by one staff on the first and second floors for the day shift, one PSW for the first floor and two PSWs for the second floor afternoon shift, and one PSW for the evening second floor shift.
On an identified date, the home was below the usual staffing complement by two PSWs on the first floor and second floor day shifts, one PSW for the afternoon shift on the first and second floors.
On an identified date, the home was below the usual staffing complement by one PSW on the first floor day shift, one PSW on the second floor afternoon shift.
On an identified date, the home was below the usual staffing complement by one

PSW on the first floor day shift, and one PSW on the first floor afternoon shift.

During interview with Inspector #107, PSW #147 stated they were unable to get all the documentation completed when staffing was below the usual complement.

3. Inspector # 750 requested to see the licensee's written staffing plan for the organized program of nursing and personal support to identify if the requirements in O. Reg 79/10, s 31(3) were included.

A binder identified as "Shift Routines" was provided and confirmed to be the home's staffing plan by the Director of Care (DOC) #104 on an identified date.

The binder contained a "Personal Support Workers (PSW) Working Short Algorithm", dated January 2019, that provided steps to be taken in the event of a sick or absent call in. There was no such algorithm found for registered staff. Additionally, the binder was divided into bath PSW, PSW days, evenings and nights, Registered Practical Nurses (RPN) and Registered Nurses (RN). Within each identified section was an outline of the identified roles' shift duties, including day (0600-1400) and evening (1400-2200) shifts for PSWs, when full staff, which was five (5) staff, short one PSW leaving four (4) staff, and short two PSWs, leaving three (3) staff for each floor, PSW night (2200-0600) and bathing shifts (0600-1400 and 1400-2200). RPN routines included day/evening (0600-1800), night (1800-0600) for both floors and additional routines for Fridays on the second floor for days (0600-1400) and evenings (1400-2200); it was noted on the RPN night shift routine, to assist with PSW rounds and break coverage if short PSWs. RN day (0600-1400), evening (1400-2200), and nights (2200-0600) were in the binder and on each of the shift routines, it noted if short an RPN, a RN will assume the RPN's duties.

The binder did not include:
-a written plan that set out the organization and scheduling of staff shifts;
-a written plan that identified how the home promotes continuity of care, minimizing the number of different staff members who provide nursing and personal support services to residents in the home;
-a written backup plan for nursing and personal care staff; or
-written updates or evaluations of the staffing plan.

In an interview with the Administrator #105, they confirmed that the home did not have the identified areas included in the home's staffing plan, as noted above.

In summary, over the course of the inspection, the licensee did not meet the staffing mix set out by the home, did not meet the assessed care and safety needs of the residents and did not ensure a staffing plan was in place in the home.

The licensee failed to ensure that the home had a written staffing plan that included the home's process for scheduling staff shifts, how the home minimizes the number of different staff members and continuity of care, a backup plan that outlines the expectations set out in the Long Term Care Homes Act s. 8(3) and an annual evaluation of the plan.

The severity of this issue was determined to be a level 2 as there was minimal discomfort to the residents. The scope of the issue was a level 3 as it was widespread. The home had a level 3 compliance history as there was on-going noncompliance with this subsection of the Act that included:

• Compliance Order/Director Referral issued on December 14, 2018, (2018_756583_0014) complied on June 13, 2019.

Additionally, the LTCH has a history of 24 other compliance orders in the last 36 months.
(750)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 06, 2020

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. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 33 (1).

Specifically, the licensee must:
1. Ensure residents #005, #016, #019 and all other residents are bathed, at a minimum twice a week by the method of their choice.

Grounds / Motifs :

1. 1.The licensee failed to ensure that each resident in the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A complaint was submitted to the Director, regarding concerns about resident #001's personal hygiene.

The home's bathing paper documentation for identified months were reviewed. The review identified two weeks, in two separate months, which each had three dates, Thursday AM, PM, Friday AM, PM and Saturday AM, PM, that were blank for all residents on an identified unit.

In an interview with the Quality Improvement staff #103, they confirmed that if dates were not identified on the sheet then baths did not occur that day. They also noted that during the identified dates in the identified months, baths did not occur due to the

home being short staff and that residents would not have received their baths twice a week.

The home provided copies of the daily assignment sheet during the identified weeks for both months. The full staffing compliment for day and evening shifts included five (5) PSWs; one PSW assigned to bathing and four PSWs to manage care.
The following dates were identified for the identified unit:
On an identified date, the home was below the usual staffing compliment by two PSWs on day shift and one PSW on evening shift,
On identified date, the home was below the usual staffing compliment by two PSWs on day shift and one PSW on evening shift, and
On identified date, the home was below the usual staffing compliment by two PSWs on both day and evening shifts.
On identified date, the home was below the usual staffing compliment by two PSWs on day shift,
On identified date, the home was below the usual staffing compliment by one PSW on day shift and two PSWs on evening shift, and
On identified date, the home was below the usual staffing compliment by one PSW on day shift, with two PSWs working a short shift in the morning only and two PSWs on the evening shift.

Three residents, resident #005, resident #016, and resident #019, were randomly selected from both of the identified lists in the identified months to further review.

A) A review of the paper documentation and point of care (POC) records for resident #005, identified baths were documented on three specified dates, and not again until a later specified date. In review of a calendar identified that one of the identified dates was in one week and the other fell in the following week, therefore identifying that resident #005, only received one bath in the identified week. In another month, resident #005 had a documented bath and the next documented bath was beyond a week, therefore only receiving one bath during that identified week again.

In an interview with DOC #104, they confirmed that during the identified two weeks, in two different identified months, resident #005 was only offered and provided one bath on each occasion. DOC #104 acknowledged that the reason resident #005 was not offered and provided the minimum two baths was due to short staffing.

The home failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

B) A review of the paper documentation and POC records for resident #016, identified baths were documented for seven dates between two months. The review indicated that resident #016 was provided one bath during an identified week.

In an interview, DOC #104 confirmed that resident #016 was only offered and provided one bath during the identified week, and the reasoning was due to the home being short staffed during an outbreak.

The home failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

C) A review of the paper documentation and POC records for resident #019, identified documented baths 11 baths in the identified three months. In review of the identified weeks, resident #019 was bathed once during two specified weeks.

In an interview, DOC #104 confirmed that resident #019 was only offered and provided one bath during the identified weeks. DOC #104 indicated that the home was in outbreak and short staffed during both weeks identified.

The home failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The severity of this issue was determined to be a level 2 as there was minimal discomfort to the residents. The scope of the issue was a level 3 as it was widespread. The home had a level 3 compliance history as there was on-going noncompliance with this subsection of the Act that included:

• Compliance Order (CO)/Director Referral issued on December 14, 2018,

(2018_756583_0014), complied June 13, 2019;
• CO/Director Referral issued on February 26, 2018, (2017_695156_0008), reissued November 20, 2018;
• CO issued on July 12, 2017, (2017_574586_0012), reissued on February 26, 2018.

Additionally, the LTCH has a history of 21 other compliance orders in the last 36 months.
(750)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 06, 2020

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: 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,

(a) 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 nutrition care and dietary services and hydration;

(b) the identification of any risks related to nutrition care and dietary services and hydration;

(c) the implementation of interventions to mitigate and manage those risks;

(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and

(e) a weight monitoring system to measure and record with respect to each resident,

(i) weight on admission and monthly thereafter, and

(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Order / Ordre :

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

The licensee must be compliant with O.Reg. 79/10, s. 68 (2) (a),(b)

Specifically, the licensee must:
1. Ensure that residents with identified nutrition and hydration risks, including residents #008, #035, #032, #036, #030, #009, and any other resident with identified nutrition and hydration risks have their food and fluid intake recorded and monitored.
2. Standardize and implement the policies related to thickened fluids and dysphagia management.
3. Provide education for PSWs related to the provision of and documentation of the Sip n Go hydration program.
4. Keep a record of the attendance and education provided for reference by Inspectors at a later date.
5. Ensure that the home's nutrition and hydration program provides methods for flagging residents with nutrition and hydration risks and those eating or drinking poorly, for prompt follow up or referral as necessary.
6. Conduct regular audits, at the frequency of the home's choosing, to monitor that residents with nutrition and hydration risks have their food and fluid intake documented and monitored and that nutrition and hydration risks are identified. Document the outcome of each audit, and revise the processes, as necessary, based on the results of the audits.

Grounds / Motifs :

1. 1. The licensee failed to ensure that the nutrition care and hydration programs included: the implementation of policies and procedures related to nutrition care and dietary services and hydration and the identification of any risks related to nutrition care and dietary services and hydration.

The home had developed policies that identified a system for documenting the food and fluid intake of residents at nutrition and hydration risk, however, the policies had not been implemented by staff.

Policy NDM-III-114, "Meal Service – Pleasurable Dining," date noted, directed PSW or nursing staff to document all resident food and fluids consumed in the Point of Care Tasks. Food and fluid intake records, under the Point of Care Tasks, for two identified months were incomplete and staff had not recorded food and fluid intake for residents at nutrition and hydration risk.

During an interview with Registered Dietitian #125 on two specified date, they confirmed that there were large gaps in the food and fluid intake documentation, resulting in lack of information for nutritional assessments and for the evaluation of the effectiveness of nutritional interventions.

The nutrition and hydration program at the home was unable to identify risks related to nutrition and hydration and did not allow for the evaluation of food and fluid intake of residents with identified risks related to nutrition and hydration.

Nutrition and hydration risks observed by Inspector #107 in the dining room or at snack service were not identified in food and fluid intake documentation, progress notes, or through referrals to the Registered Dietitian.

Examples where the home's program for nutrition care and hydration did not include the implementation of policies and procedures and identification of risks related to nutrition care and dietary services and hydration included:

A) Resident #008 was identified at high nutrition risk and had a documented weight loss below their goal weight range in an identified month. The resident was observed at the a specified date, lunch meal. Staff assisted the resident with their fluids and dessert at the meal. After one sip of fluids the resident began coughing and the resident did not take any additional fluids at the meal. Food and fluid intake records for the identified date, were not completed for the lunch meal. The resident's poor intake of fluids was not recorded.

The resident had a plan of care that directed staff to provide an identified food item at an identified snack pass. On five out of six days reviewed between an identified time period, prior to a nutrition assessment, the resident's identified snack intake records reflected not applicable, or the information was incomplete, resulting in the inability to evaluate the effectiveness of the strategy from the available documentation.

B) Resident #035 was identified at high nutrition risk with significant weight loss. Inspector #107 observed the resident at the lunch meal and an identified snack pass on an identified date. The resident did not consume their full meal or fluids at the lunch meal, required more assistance than was provided, and the resident did not consume a beverage or snack at the identified snack pass. Documentation on the

resident's food and fluid intake records were blank for the identified date (no records for the whole day), and documentation in the progress notes did not identify the poor intake that day or that additional assistance was required.

Documentation on the resident's food and fluid intake records was incomplete with 32% of meals and 44% of snacks not recorded for an identified month, effecting the evaluation of the resident's nutrition and hydration.

C) Resident #032 was identified at high nutrition risk with an unintended weight loss over three months. The resident was significantly underweight with a noted low body mass index in a specified month. At the lunch meal on an identified date, the resident was significantly coughing while being assisted with drinking their fluids and the fluids were removed from the resident for the rest of the meal. PSW #112 stated they were going to get a dietary referral to Registered Dietitian #125 for further assessment, however, documentation in the resident's clinical health record between two identified dates, did not include mention of the coughing/choking while drinking fluids, poor intake of fluids at the meal, or mention of a referral to the Registered Dietitian for further assessment. During interview with Inspector #107, the Registered Dietitian stated that staff had mentioned something briefly but confirmed that there was nothing documented to identify the nutritional concerns and no referral to the Registered Dietitian was completed.

Documentation on the resident's food and fluid intake records was incomplete with 28% of meals and 39% of snacks not recorded for an identified month, effecting the evaluation of the resident's nutrition and hydration. Documentation of the resident's hydration for an identified two week period, reflected intake less than their fluid requirement, and less than 75% of their fluid requirement, however, documentation was incomplete and it was unclear what the resident's actual hydration pattern was. Concerns could not be accurately identified from the documentation available.

D) Resident #036 was observed at an identified snack pass on a specified date. The resident's snack was placed out of reach on the resident's bedside table and staff did not return to assist the resident with their snack. The resident did not consume a beverage or a snack at the snack service. The resident identified to Inspector #107 that they were hungry and thirsty prior to the supper meal and stated that they were not usually offered a snack in the afternoon. Documentation of the specified snack for the identified date, was not completed.

Documentation on the resident's food and fluid intake was incomplete with 45% of snacks not recorded for an identified month, effecting the evaluation of the resident's intake and hydration level, including the provision of snacks.

E) Resident #030 was identified at high nutrition risk. At the identified date, lunch meal, the resident required more assistance than was provided to the resident. Documentation reflected the resident refused the lunch meal. At the observed afternoon snack pass on the identified date, the resident did not consume their pureed snack. The resident refused an evening snack. Food and fluid intake records were incomplete for the afternoon and evening snack pass.

Documentation of the resident's food and fluid intake records was incomplete with 26% of meals and 49% of snacks not recorded for an identified two week period.

F) Resident #009 was identified at nutrition risk. The resident required thickened fluids and a pureed texture snack. At the identified date afternoon and evening snack pass the resident did not consume a snack or beverage. Documentation was incomplete for the afternoon and evening snack pass on the identified date.

Documentation of the resident's food and fluid intake records was incomplete with 24% of meals and 42% of snacks not recorded for an identified month.

G) Documentation for most of the residents reviewed was missing on five identified dates.

On an identified date, the home was below the usual staffing complement by two PSWs and an RPN on the day shift for the first floor, one PSW on days for the second floor, two PSWs for the afternoon shift on the first floor and one PSW for the afternoon shift on the second floor.
On another identified date, the home was below the usual staffing complement by one staff on the first and second floors for the day shift, one PSW for the first floor and two PSWs for the second floor afternoon shift, and one PSW for the evening second floor shift.

On an identified date, the home was below the usual staffing complement by two PSWs on the first floor and second floor day shifts, one PSW for the afternoon shift

on the first and second floors.

On an identified date, the home was below the usual staffing complement by one PSW on the first floor day shift, one PSW on the second floor afternoon shift.

On an identified date, the home was below the usual staffing complement by one PSW on the first floor day shift, and one PSW on the first floor afternoon shift.

During interview with Inspector #107, PSW #147 stated they were unable to get all the documentation completed when staffing was below the usual complement.

H) Nutrition Manager #120 provided policies to Inspector #107 related to the preparation and provision of thickened fluids and dysphagia management. The policies did not contain a policy number, title, or date of implementation. The Nutrition Manager confirmed that the policies had not yet been implemented and did not provide implemented policies to the Inspector.

I) Not all staff were consistent in the way they documented fluids consumed for an identified program. The Point of Care Task identified that residents were to be offered additional fluids to residents every two hours.

During interview with Inspector #107, PSW #107 stated that the fluids times and the identified program times often corresponded (breakfast at 0800 hours, morning snack 1000 hours, lunch at 1200 hours, afternoon snack 1400 hours, 1800 hours supper, evening snack 2000 hours) so the PSW recorded the fluids taken at meals and documented the same fluids taken in the identified program record. This would result in a duplication of a resident's intake, resulting in the resident appearing to consume more fluids than they did. During interview with Inspector #107, the Director of Care (DOC) #104 confirmed that staff were to record each beverage only once. Staff, including the Registered Dietitian, would not be able to accurately evaluate a resident's hydration status.

The home's nutrition care and hydration policy related to documentation of food and fluid intake and dysphagia management were not implemented and the program did not allow for the identification and management of risks related to nutrition and dietary services and hydration, with a system that enabled the evaluation of nutrition

and hydration intake of residents. (107)

The severity of this issue was determined to be a level 2 as there was minimal discomfort to the residents. The scope of the issue was a level 3 as it was widespread. The home had a level 3 compliance history as there was on-going noncompliance with this subsection of the Act that included:

Voluntary Plan of Correction (VPC) issued July 12, 2017 (2017_574586_0012) related to O.Reg. 79/10, s. 68. (2) (b)

Additionally, the LTCH has a history of 24 other compliance orders in the last 36 months.

(750)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2020

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: 007

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee must be compliant with Long Term Care Homes Act, 2007, s. 8(3).

Specifically, the licensee must:
1. Ensure that a registered nurse who is both an employee of the home and a member of the regular nursing staff is working at all times.
2. Ensure that the registered nurse who is on duty, is present in the home at all times.
3. Provide evidence that all shifts were covered by a registered nurse who is an employee of the home and that the registered nurse was present in the home at all times during their assigned shift.

Grounds / Motifs :

1. 1. The licensee failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times.

A complaint was submitted to the Director, related to 24 hour nursing care.

Ontario Regulation 79/10, section 45, outlines exceptions for the requirement of one registered nurse on duty and present at all times, for homes with a licensed bed capacity of more than 64 beds and fewer than 129 beds, in the case of an emergency where the backup plan is met. A RN who works at the home pursuant to

a contract or agreement between the licensee and an employment agency or other third party may be used if, the director of nursing and personal care or a RN who is both an employee of the licensee and a member of the regular nursing staff is available by telephone, and a registered practical nurse who is both an employee of the licensee and a member of the regular nursing staff is on duty and present in the home.

Ontario Regulation 79/10 defines an emergency as an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long term care home.

Cedarwood Village would qualify for this exemption, in the case of an emergency, as the total number of beds in the home was 90.

The current planned staffing pattern for registered nursing staff, for the direct care of residents, included three Registered Nurse (RN)s working 8 hour shifts for a total of 24 hours per day and 5 Registered Practical Nurses (RPNs), two working 12 hour shifts and three working 8 hour shifts, for a total of 24 hours per day, as identified on work schedules provided by the home and confirmed by ward clerk #128.

The home's RN schedules for three identified months were reviewed and identified no RN coverage for eight identified shifts.

The Director of Care (DOC) # 104, confirmed that there were no RNs in the home on the identified dates and associated shifts.

In an interview with the Administrator #105, they confirmed that the need to fill these RN shifts were not the result of emergency situations as outlined above. Administrator #105 also confirmed that the home did not have back up plan for registered staff.

The home did not ensure that there was at least one registered nurse who was an employee of the licensee and was a member of the regular nursing staff on duty and present in the home at all times. [s. 8. (3)]

The severity of this issue was determined to be a level 2 as there was minimal discomfort to the residents. The scope of the issue was a level 3 as it was

widespread. The home had a level 3 compliance history as there was on-going noncompliance with this subsection of the Act that included:

• Compliance Order (CO) served on December 14, 2018, (2018_756583_0014), complied on June 13, 2019;
• CO/Director Referral served on February 26, 2018, (2017_695156_0008), complied on May 1, 2018;
• CO served on July 12, 2017, (2017_574586_0012), reissued on February 26, 2018.

Additionally, the LTCH has a history of 21 other compliance orders in the last 36 months.

(750)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 06, 2020

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

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

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

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.

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

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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

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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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 30th day of July, 2020 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by STACEY GUTHRIE (750) - (A1)

Ontario

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Ministère des Soins de longue durée

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Service Area Office / Bureau régional de services : Hamilton Service Area Office