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
Jan 18, 2021	2020_689586_0028 (A2)	023819-19, 009685-20, 010269-20, 011449-20, 011450-20, 011451-20, 011452-20, 011453-20, 011454-20, 011455-20, 013531-20, 013825-20, 017008-20	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 JESSICA PALADINO (586) - (A2)

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

PHI removal from public report.

Issued on this 18th day of January, 2021 (A2)

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 JESSICA PALADINO (586) - (A2)

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): November 17, 18, 19, 20, 23, 24, 25, 26, 27, 30 and December 2, 3, 9, 2020.

The following Complaint Inspections were completed concurrently:

013531-20 and 017008-20 related to multiple care areas;

013825-20 related to hot temperatures in the home; and,

010269-20 and 009685-20 related to fall's prevention.

The following Follow Up Inspections were conducted concurrently:

023819-19 related to continence care;

011455-20 related to nutrition care;

011454-20 related to bathing;

011453-20 related to staffing;

011452-20 related to training;

011451-20 related to dining and snack service;

011450-20 related to staffing; and,

011449-20 related to foot care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nutrition Manager (NM), Resident Assessment Instrument (RAI) Co-ordinators, Quality Improvement Co-ordinator (QIC), Clinical Co-ordinator (CC), Program Manager (PM), Maintenance Manager (MM), Behavioural Support Ontario (BSO), Registered Dietitians (RD), Ward Clerks, restorative aide, dietary staff, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSWs), residents and families.

During the course of the inspection, the inspector(s) toured the home, observed resident care and reviewed resident health records, internal compliance plans, audits, complaint records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home
Snack Observation
Sufficient Staffing
Training and Orientation

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

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 31. (3)	CO #004	2020_837750_0005	506
O.Reg 79/10 s. 33. (1)	CO #005	2020_837750_0005	506
O.Reg 79/10 s. 51. (1)	CO #001	2019_546750_0017	506
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #001	2020_837750_0005	506
O.Reg 79/10 s. 68. (2)	CO #006	2020_837750_0005	586
LTCHA, 2007 S.O. 2007, c.8 s. 76. (1)	CO #003	2020_837750_0005	506
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #007	2020_837750_0005	506

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. 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 has failed to ensure that residents were provided with food and fluids that were safe.

On two consecutive dates during the inspection, pureed salad was observed being served to residents at lunch. The pureed salad was a mixed consistency of solids and thin liquid, did not hold it's shape and the thin liquid was noted to be

separating from solids and pooling across residents' plates.

The home's "Production of Texture Modified Foods and Thickened Fluids" policy required staff to prepare pureed foods as per International Dysphagia Diet Standardisation Initiative (IDDSI) Diet Texture Standards and Testing Methods. The policy indicated the standard was that pureed food should have a smooth texture with no lumps, should hold it's shape on a spoon and liquid must not separate from solids.

Cook #123 explained that dietary staff were trained on the IDDSI Diet Texture and Testing Methods but that these new standards and testing methods had not been implemented for texture modified food yet. They stated that if a pureed food was prepared and did not meet the home's pureed texture standards, they would try to fix it by adding thickener and if the standardized recipe was not yielding the right consistency, they would adjust the recipe. They said dietary staff would also be responsible for testing and ensuring texture modified food and thickened fluids met the home's standards at point-of-service.

Dietary Aide #126 stated that when the home first implemented IDDSI standards for fluids, they audited all of the home's thickened fluid recipes using the IDDSI flow test with the Nutrition Manager; however, they had not completed an IDDSI flow test since then.

The NM indicated that staff had been trained on the home's thickened fluid and food texture standards and were expected to visually monitor and make sure that the fluid and food being served to residents was meeting those standards. They stated the home had implemented IDDSI standards for thickened fluids and pureed food at that time. Staff had received training on how to complete an IDDSI test but were not comfortable doing tests at that time and required more training. They said staff were expected to call them if they felt an item did not meet the home's standards, at which time they would complete an IDDSI test to determine if the item met the fluid and food texture criteria. They stated if a thickened fluid or pureed food did not meet the home's standards it should not be served to residents.

The NM confirmed that the pureed salad observed at lunch that day would not meet the home's pureed texture standards and that they were not aware and were disappointed to hear it was served to residents. They said they expected the cook to monitor and ensure that foods being prepared and served to residents

were safe and met the home's texture standards. They also confirmed there were no fully documented IDDSI audits completed.

Serving improperly thickened food and fluids to residents provided a choking risk.

Sources: The licensee's policy, "Production of Texture Modified Foods and Thickened Fluids" policy (last revised September 28, 2020), internal compliance plan and documentation, observations of food and fluid preparation and service; and interviews with dietary staff, the Nutrition Manager and other staff. [s. 11. (2)]

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the licensee's responsive behaviour policy was complied with.

Upon occurrence of an episode of a physically responsive behaviour, the licensee's policy directed staff to initiate an incident report to be able to analyze the incident and determine effectiveness of current strategies. This would automatically generate a progress note to document the risk of responsive behaviours, with referral to the plan of care.

The policy also directed staff to contact the DOC or designate immediately.

During the inspection, resident #009's substitute decision-maker (SDM) was visiting with the resident when an altercation ensued between the resident and co-resident #016. The family member reported this to RPN #119.

Upon review of resident #016's health record, there was no documentation of the incident, nor was an incident report completed. RPN #104 and the DOC confirmed this. The DOC also confirmed that they were not notified of the incident by RPN #119.

The licensee's responsive behaviour policy was not complied with. Not internally reporting an incident of physical aggression posed a risk to co-residents as staff were not aware of the incident which resulted in a delay in re-assessment of the aggressor and prevention of future occurrence.

Sources: The licensee's policy 'Responsive Behaviours Management' (last approved November 17, 2020), resident #016's and #009's health records, security camera footage, and interviews with resident #009's SDM, RPN #104, RN #126, RAI Co-ordinator #128 and the DOC. [s. 8. (1) (b)]

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 that any plan, policy, protocol, procedure, strategy or system put into place is in compliance with and is implemented in accordance with applicable requirements under the Act, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

(A2)
1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A. The licensee had a compliance order (CO) which was issued under Ontario Regulation (O.Reg) 79/10, r. 33. (1), related to the bathing of residents, that was being inspected upon. While reviewing the clinical record for resident #013, it was identified that they only received one bath per week as per the point of care documentation.

A review of the bathing records with the QIC confirmed that the resident did receive two baths per week; however, not all were documented in the resident's clinical record.

An interview with PSW #113 confirmed that they did complete resident #013's baths on two identified dates in 2020 and that this should have been documented.

Sources: CO #005 from inspection report #2020_837750_0005, resident #013's clinical record, the home's bathing records and interview with PSW #113. (506).

B. The licensee had a CO issued under O.Reg 79/10, r. 68 (2), related to the nutrition and hydration risks to residents, that was being inspected upon. While reviewing the clinical records for residents #004 and #005, it was identified that there was some missing documentation regarding their food and fluid intake as per POC documentation.

A review of the monthly high risk nutrition audits over a two-month period in 2020 identified that though much improved, there continued to be missing food and fluid intake documentation. This was confirmed through interviews with RD's #134 and #138.

The lack of documentation posed a risk to residents as it did not give the RD and registered staff the ability to properly assess each resident's food and fluid intake.

Sources: CO #002 from inspection report #2020_837750_0005, residents #004 and #005 clinical records, 'Nutrition Care Audit - Residents at High Nutritional Risk' forms and interviews with RD's #134 and #138. [s. 30. (2)]

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 that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and identify and implement interventions.

Resident #016 had an extensive history of physically responsive behaviours toward co-residents. The resident continued to have incidents of physical aggression toward co-residents; however, they were discharged from BSO. After that, they continued to have further incidents.

In an interview with BSO #110, they acknowledged that the resident did continue to have physically responsive incidents and that they should not have been discharged from BSO. The BSO also confirmed that the subsequent incidents would have warranted a re-referral to BSO by the home; however, this was not done. RAI Co-ordinator #128 confirmed they were aware of the incidents; however, a re-referral was not made. In an interview with the DOC, they acknowledged that the home had not exhausted all options pertaining to the resident's responsive behaviours and that resident #006 and co-residents were not being protected from potentially harmful interactions.

The lack of re-assessments or use of external care providers resulted in physical harm to co-residents as well as a risk of continued physical altercations between resident #016 and co-residents.

Steps were not taken to minimize the risk of altercations and potentially harmful interactions between and among residents.

Sources: Resident #016's health record and interviews with BSO #110, RAI Co-ordinator #128 and DOC. [s. 54.]

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 that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and identify and implement interventions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

s. 73. (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 :

(A2)
1. The licensee has failed to ensure that residents were provided with food and fluids at a temperature that was palatable to the residents.

Temporary dining measures were in place for social distancing which involved having the resident eat via tray service in the hallway outside of their rooms. Staff would plate the orders from the servery and deliver the trays to the residents by one side of the hallway at a time. The trays included hot and cold drinks, soup, entrée and dessert.

On an identified date during the inspection, at 1145 hours, dietary staff were beginning to plate resident meals in the first floor serving area. Once food was

plated for each resident the plate was then placed on a tray on an uninsulated cart. Staff left the serving area with the cart and started distributing trays of food and beverages to residents at 1207 hours. On the second floor, plating began at 1200 hours and the first trays were served at 1215 hours.

The following day, at 1150 hours, dietary staff were beginning to plate resident meals in the second floor serving area. Once food was plated for each resident the plate was placed on a tray on an uninsulated cart. Coffee and tea had already been poured into mugs that were placed uncovered on resident trays. Staff left the serving area with the cart and started distributing trays of food and beverages to residents at 1209 hours.

During the observations, PSW's #106, #114 and #115 and dietary aides #116 and #117 all voiced concerns about the current dining measures, indicating that food would get cold by the time it reached the residents. They indicated that residents had been complaining of cold food since these measures were put into place in May 2020.

Resident #017 told Long-Term Care Homes (LTCH) Inspector #506 that the food came out lukewarm.

Food Quality Check Audit forms were provided by the NM. The August 13, 2020, audit said, "Cold food due to COVID-19".

In an interview with the NM, they acknowledged they were aware of the cold food concerns brought forward by residents.

Serving unpalatable food to residents posed a risk of poor food intake.

Sources: Lunch service observations, audit forms, and interviews with residents and staff. (721). [s. 73. (1) 6.]

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

Resident #009's written care plan identified a texture-modified diet and required staff to assist the resident with parts of their meal to promote adequate nutritional and fluid intake.

On an identified date during the inspection, resident #009 was served their lunch meal at 1215 hours. The tray was kept covered in front of them until PSW #106 was available to feed the resident at 1230 hours; 15 minutes later. In an interview with PSW #106, they confirmed that resident #009 required total assistance most days and that residents should not be served their meal until someone was available to assist them.

The following day, LTCH Inspector #721 observed a PSW serve resident #009 a tray of uncovered food and then left the resident alone and without assistance for a period of seven minutes. During this time the resident attempted to feed themselves with their hands and dropped food all over their tray and clothing.

Serving food without the proper assistance available to residents posed a risk of poor food intake as the resident's food could get cold and part of their meal was dropped on their tray and clothing.

Sources: Observation of lunch service, resident #009's health record and interview with staff. [s. 73. (2) (b)]

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 to ensure that foods and fluids are being served at a temperature that is both safe and palatable to the residents; and, to ensure that 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that resident #009's SDM was given access to his or her records of personal health information, including his or her plan of care.

Resident #009 had a fall. The resident's SDM requested a copy of the incident report but was denied. In an interview with RPN #104, they confirmed the SDM was denied this request. RN #104 and the DOC confirmed that the resident's SDM had the right to copies of the resident's personal health record and this should have been provided to them.

Sources: Resident #009's health record, Point Click Care (PCC) communication note and interviews with resident #009's SDM, RPN #104, RN #102 and the DOC. [s. 3. (1) 11. iv.]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to comply with s. 24 (1) 2. in that a person who had reasonable grounds to suspect abuse of a resident, failed to report the alleged abuse immediately to the Director in accordance with s. 24 (1) 2 of the LTCHA. Pursuant to s. 152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

A. Resident #016 had a two incidents of physical aggression toward co-residents resulting in injury.

The DOC acknowledged that these two incidents were not reported to the Director.

B. Resident #002's SDM reported an incident of alleged abuse by a staff member toward the resident. RN #102 went to speak to the resident who relayed the same story.

The DOC acknowledged that this incident was not reported to the Director.

Sources: The licensee's policies 'Responsive Behaviours Management' (last approved November 17, 2020) and 'Critical Incidents - Mandatory Reporting' (last approved August 11, 2020) , LTCH.net, resident #016's and #022's health records and interview with the DOC. [s. 24. (1)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Findings/Faits saillants :

1. A. The licensee has failed to comply with CO #001 from Inspection #2020_837750_0005 served on July 30, 2020 with a compliance due date (CDD) of November 6, 2020.

Specifically, the licensee was ordered, but did not comply, with the following:
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.

An interview with the DOC confirmed that they did not complete the required education to all staff who provide foot care to residents, outlining the home’s expectations and each discipline’s roles and responsibilities, nor did they maintain records of any training materials used to educate, dates training would have been provided or staff attendance.

Lack of proper education posed a risk to residents not receiving the appropriate foot care.

Sources: CO #001 from #2020_837750_0005 and interview with the DOC. (506).

B. The licensee has failed to comply with CO #006 from Inspection #2020_837750_0005 served on July 30, 2020 with a CDD of September 30, 2020.

Specifically, the licensee was ordered to, but did not comply with, the following:
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.

A review of the licensee's updated policy, 'Encouraging Fluid Intake', did not provide clear direction to staff on how to properly make RD referrals for the Sip'n'Go program when residents had poor fluid intake. This was confirmed by the DOC.

Due to this, registered staff were following different protocols based on their understanding. RN's #102 and #134 and RPN #129 all stated they were not clear on the requirement to send RD referrals. As a result, RD referrals were not made for all residents who had poor fluid intake, including residents #030, #031, #032 and #033.

RN #144 acknowledged that they did not send RD referrals after putting the residents on the Sip'n'Go program. RD #134 confirmed that they had not received any referrals for poor fluid intake since the CDD.

The home's nutrition and hydration program did not provide methods for flagging residents with nutrition and hydration risks and those eating or drinking poorly, for prompt follow up or referral as necessary. This posed a risk of residents not being appropriately assessed for their hydration needs.

Sources: CO #002 from inspection report #2020_837750_0005, the home's compliance plan package including policy, 'Encouraging Fluid Intake' (revised September 28, 2020) and interviews with registered staff, RD #134 and the DOC. [s. 101. (3)]

Issued on this 18th day of January, 2021 (A2)

[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 JESSICA PALADINO (586) - (A2)
Inspection No. / No de l'inspection :	2020_689586_0028 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	023819-19, 009685-20, 010269-20, 011449-20, 011450-20, 011451-20, 011452-20, 011453-20, 011454-20, 011455-20, 013531-20, 013825-20, 017008-20 (A2)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 18, 2021(A2)
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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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To Maplewood Nursing Home Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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Order # / No d'ordre: 001

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

Linked to Existing Order / Lien vers ordre existant: 2020_837750_0005, CO #002;

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 LTCHA.

Specifically, the licensee shall prepare, submit and implement a plan to ensure residents are provided with texture-modified foods and fluids that are safe.

The plan must include:
1. The development of a system to monitor on an ongoing basis and to audit that thickened fluids and pureed foods are being prepared per the home's procedures and are meeting the home's standards for thickened fluids and texture modified foods. The auditing is to be done daily for one week, then weekly thereafter. A documented record must be maintained of each audit, including the date the audit was completed, the outcome of the audit, and actions taken as a result of the audit;

2. The review of the home's policy related to thickened fluids and texture modified foods to ensure that this policy is fully implemented and complied with. The home must keep a documented record of this review, including the date of the review and who participated in the review; and,

3. The re-education of all staff who would prepare thickened fluids and texture modified foods for residents, on the home's policy related to thickened fluids and texture modified foods, the home's standards for thickened fluids and texture modified foods, and the process to be followed when it is identified that thickened fluids or texture modified foods do not meet standard criteria. A documented record must be maintained of the education provided, including the names of staff who received the education, date the education was provided, and content and format of the education.

Please submit the written plan for achieving compliance for inspection #2020_689586_0028 to Jessica Paladino, LTC Homes Inspector, MLTC, by email to HamiltonSAO.MOH@Ontario.ca, by January 15, 2021.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were provided with food and fluids

that were safe.

Compliance Order (CO) #002 related to s. 11 (2) from inspection #2020_837750_0005 issued on June 3, 2020, with a compliance due date (CDD) of September 30, 2020, is being re-issued as follows:

On two consecutive dates during the inspection, pureed salad was observed being served to residents at lunch. The pureed salad was a mixed consistency of solids and thin liquid, did not hold it's shape and the thin liquid was noted to be separating from solids and pooling across residents' plates.

The home's "Production of Texture Modified Foods and Thickened Fluids" policy required staff to prepare pureed foods as per International Dysphagia Diet Standardisation Initiative (IDDSI) Diet Texture Standards and Testing Methods. The policy indicated the standard was that pureed food should have a smooth texture and no lumps, should hold its shape on a spoon and liquid must not separate from solids.

Cook #123 explained that dietary staff were trained on the IDDSI Diet Texture and Testing Methods but that these new standards and testing methods had not been implemented for texture modified food yet. They stated that if a pureed food was prepared and did not meet the home's pureed texture standards, they would try to fix it by adding thickener and if the standardized recipe was not yielding the right consistency, they would adjust the recipe. They said dietary staff would also be responsible for testing and ensuring texture modified food and thickened fluids met the home's standards at point-of-service.

Dietary Aide #126 stated that when the home first implemented IDDSI standards for fluids, they audited all of the home's thickened fluid recipes using the IDDSI flow test with the Nutrition Manager; however, they had not completed an IDDSI flow test since then.

The NM indicated that staff had been trained on the home's thickened fluid and food texture standards and were expected to visually monitor and make sure that the fluid and food being served to residents was meeting those standards. They stated the home had implemented IDDSI standards for thickened fluids and pureed food at that time. Staff had received training on how to complete an IDDSI test but were not

comfortable doing tests at that time and required more training. They said staff were expected to call them if they felt an item did not meet the home's standards, at which time they would complete an IDDSI test to determine if the item met the fluid and food texture criteria. They stated if a thickened fluid or pureed food did not meet the home's standards it should not be served to residents.

The NM confirmed that the pureed salad observed at lunch that day would not meet the home's pureed texture standards and that they were not aware and were disappointed to hear it was served to residents. They said they expected the cook to monitor and ensure that foods being prepared and served to residents were safe and met the home's texture standards. They also confirmed there were no fully documented IDDSI audits completed.

Serving improperly thickened food and fluids to residents provided a choking risk.

Sources: The licensee's policy, "Production of Texture Modified Foods and Thickened Fluids" policy (last revised September 28, 2020), internal compliance plan and documentation, observations of food and fluid preparation and service; and interviews with dietary staff, the Nutrition Manager and other staff.

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

Severity: The improperly pureed food items posed an actual choking risk to residents.

Scope: This non-compliance was a pattern as improperly pureed food was identified during two meal observations on different dates.

Compliance History: A CO is being re-issued for the licensee failing to comply with s. 11 (2) of the LTCHA 79/10. This subsection was issued as a CO on June 3, 2020, during inspection #2020_837750_0005. In the past 36 months, one other CO to this subsection of the legislation was issued, which had been complied. (721)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 01, 2021

Order(s) of the Inspector

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Ordre(s) de l'inspecteur

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REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Order(s) of the Inspector

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Ordre(s) de l'inspecteur

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Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 18th day of January, 2021 (A2)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by JESSICA PALADINO (586) - (A2)

Ontario

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