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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 24, 2022	2022_911506_0004	002076-22	Proactive Compliance Inspection

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

LESLEY EDWARDS (506), LISA VINK (168)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Proactive Compliance Inspection.

This inspection was conducted on the following date(s): February 7, 8, 9, 10, 11, 14, 15 and 16, 2022.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Infection Prevention Control (IPAC) lead, Programs Manager, Resident Assessment Instrument (RAI) Coordinator, Nutritional and Environmental Manager, recreation staff, housekeeping staff, screening staff, maintenance staff, dietary staff, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Public Health Inspector, families and residents.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, infection prevention and control (IPAC) practices, meal service, medication administration, and reviewed clinical records, relevant policies and procedures, meeting minutes, training records and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Skin and Wound Care

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

- **7 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's plan of care set out clear directions to staff and others who provided direct care related to transfer status.

The plan of care for a resident under transfers that they required a specific intervention and in another part of the plan identified one of the interventions on the resident's plan of care was inaccurate.
The staff member identified what intervention the resident was currently using.

Failure to ensure that the plan of care set out clear direction regarding the transferring status of the resident had the potential for risk, if care was not provided at the level required.

Sources: Review of the plan of care, lift logos and observations of resident and interviews with RPN #118 and other staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to resident #007 and #011 related to the use of a specified treatment.

i. Resident #007 was observed with a specified treatment and confirmed they used it due to a diagnosis.

A review of the plan of care included a specified treatment.
The resident's current physician orders, electronic Medication Administration Records (eMAR) and electronic Treatment Administration Records (eTAR) did not include an order for the specified treatment.
The RPN confirmed that the resident did not have a physician's order for the treatment.
Clear direction was not provided to staff on how to administer the specified treatment.

ii. Resident #011 was observed with a specified treatment in place and confirmed they used the specific treatment.
A review of the plan of care included the specified treatment.
The resident's physician's orders did not include an order for the specified treatment.
Clear direction was not provided to staff related to the specified treatment.

Failure to ensure that the plan of care provided clear direction related to a specific treatment had the potential for the residents not to receive care in accordance with their needs.

Sources: Observations of resident #007 and #011, record review and interview with resident #007 and #011 and interview with the DOC and other staff. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the planned care was provided to resident #001, #008 and #009 as specified in their plan of care for adaptive aides.

Observation of three residents during meal service on identified dates confirmed that the three residents were not provided with their adaptive aides that were specified in the plan of care and was confirmed with staff.

The risk to the residents by not using their adaptive aides was they may have been prevented from being independent with their meals.

Sources: Meal observations of resident #001, #008 and #009, clinical records for resident #001, #008 and #009 and interviews with staff. [s. 6. (7)]

4. The licensee has failed to ensure that care set out in the plan of care was provided to a resident as specified in the plan related to a falls prevention intervention.

A resident had a plan of care which directed staff to ensure that their device was applied a specific way when not supervised. On an identified date in October 2021, the resident

sustained a fall. Progress notes identified that a staff member found the resident and their device was not applied as specified.

Sources: Review of plan of care and progress notes of a resident and interview with PSW #113 and other staff. [s. 6. (7)]

5. The licensee has failed to ensure that the care set out in the plan of care was provided to a resident related to a treatment as specified in the plan.

The Medication Review Report for a resident included an order for a specified treatment with specific instructions.

On an identified date in February 2022, observation of the resident confirmed that the specified treatment was not being provided.

Failure to provide the treatment as set out in the plan of care had the potential to alter the resident's condition.

Sources: Review of progress notes, orders and assessments of a resident, observations of the resident and interview with RPN #118 and other staff. [s. 6. (7)]

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 the planned care is provided to residents as per the plan of care and clear directions to staff and others who provide direct care, to be implemented voluntarily.

WN #2: 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 :

The licensee has failed to ensure that any actions taken with respect to resident #001, #007 and #011 under the nursing services program, as required in LTCHA s. 8 (1) including interventions and the resident's responses to a specified treatment were documented.

i.Resident #001 had an order in place for a specified treatment as needed to maintain an specified level since October 2021.
On an identified date in February 2022, the resident was observed with the specified treatment.
The clinical record did not include the use of specified treatment or the response of the resident during the time of observation.
The DOC confirmed that resident #001's use of and response to the specified treatment use was not documented.

ii. Resident #007's plan of care identified that they used a specified treatment as needed to maintain specified levels.
On an identified date in February 2022, the resident was observed with the specified treatment in use.
RPN #118 identified that as needed specified treatment would be documented in the progress notes and confirmed that it was not documented in the clinical record at the time of observation.

iii. Resident #011's plan of care identified that they had a specified treatment.
The resident was observed with the specified treatment.
A review of the clinical record did not include documentation related to the use of the specified treatment.

Failure to document the intervention of the specified treatment and the response of the treatment had the potential for inaccurate assessments of the residents.

Sources: Progress notes for resident #001, clinical record review for resident #007 and #011 physician's orders and eTAR for resident #001, observations of the resident #001, #007 and #011 and interviews with resident #007 and #011, the DOC and other staff. [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 to ensure that any actions taken with respect to residents under the nursing services program, as required in LTCHA s. 8 (1) including interventions and the resident's responses are documented, to be implemented voluntarily.

WN #3: 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 :

The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control (IPAC) program when a staff did not doff Personal Protective Equipment (PPE) before leaving a droplet/contact precaution room and wearing PPE as per Directive #3.

i. On an identified date in February 2022, a staff member did not doff their full PPE as required when exiting a droplet/contact precaution room. The staff member exited the room and removed their gown and walked down the hallway with their remaining PPE on and the gown still in their hands.
The IPAC lead confirmed that the expectation of staff was to doff all their used PPE after they completed tasks for a resident on droplet/contact precautions in their room.

ii. Not all staff complied with universal masking requirements when a double mask was worn.
On an identified date in February 2022, a staff member was observed with a surgical mask over top of their N95 mask. The IPAC lead confirmed that this was not the direction that they had been given by Public Health and that the staff member did not follow the home's IPAC program. Double masking did not comply with universal masking

procedures as per the Chief Medical Officer of Health (CMOH)'s Directive #3.

Sources: Observation of staff, interview with IPAC lead and with Public Health and other staff and review of the home's policy for Standard Precautions and Routine Practices last revised October 2018 and How to Safely Remove PPE (undated).

iii. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control IPAC program related to the use of PPE.

On an identified date in January 2022, a memo from the IPAC lead identified that a medical mask and eye protection were to be worn at all times when in a resident's room or within six feet of a resident or another person.

On an identified date in February 2022, an attendant was observed without eye protection when in close contact with resident #015, on two separate occasions.
The attendant reported that they were not directed to wear eye protection.
The DOC and IPAC lead identified that it was the current expectation that eye protection was worn including by the attendant as an additional precaution.

Failure to participate in the implementation of the IPAC program presented a risk of the spread of infection to residents, visitors and staff.

Sources: Observations of attendant #122 and interviews with the IPAC lead and other staff.

iv. The licensee has failed to ensure that all staff participated in the implementation of the IPAC program related to resident hand hygiene.

On an identified date in February 2022, during a nourishment pass on an identified floor, a staff member was observed to serve three residents a beverage without immediate prior assistance with hand hygiene.
The staff confirmed that they provided residents with hand hygiene assistance prior to meals, but that they had not provided hand hygiene prior to the distribution of the nourishment.
The home's procedure related to Personal Hygiene and Grooming, identified that all residents were to be provided or offered assistance with hand hygiene before and after all meals and snacks.

Failure to comply with the home's Hand Hygiene Program presented a minimal risk to residents related to the possible ingestion of disease causing organisms that might have been on their hands.

Sources: Observations of nourishments on the identified floor, review of Personal Hygiene and Grooming, NDM-X-30, April 18, 2020, and interview with PSW #110 and other staff.

v. The licensee failed to ensure that all staff participated in the implementation of the IPAC program related to additional precautions.

The home's procedure Additional Precaution - Appendix A identified precautions that were to be put in place to stop the spread of infections. The procedure included the need to communicate with the team members additional precautions in place for residents and that signage was to be at the entrance of bedroom doors as a method of communication.

On an identified date in February 2022, the home provided a list of residents on isolation including the type and their room numbers.
Resident #016 was on isolation, there was PPE on the resident's door; however, there was no signage to communicate the type of precautions required.

Failure to provide clear visual communication regarding resident's isolation requirements presented a risk should staff not be aware of the care needs of residents and not take precautions as required.

Sources: Tour of the home, review of residents in isolation and Additional Precautions IPAC-IV-15, October 28, 2021, and interview with the IPAC lead and other staff. [s. 229. (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 to ensure that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #4: 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: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the Residents' Council reviewed the meal and snack times.

A review of the Residents' Council and Food Committee meeting minutes did not identify any documentation of the meal and snack times being reviewed. The Administrator could not confirm when the last time members of the Residents' Council were provided the opportunity to review the meal and snack times and that it had not been done in the past year.

Sources: Residents' Council and Food Committee meeting minutes; Interview with Administrator [s. 73. (1) 2.]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

The licensee has failed to ensure that, at least once in every year, a survey was taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

Review of the Resident Council meeting minutes did not identify any indication that a satisfaction survey was completed for 2021.
The President of Family Council did not recall a survey being sent out in 2021.
The Administrator confirmed that the satisfaction survey had not been completed since 2020.

Sources: Resident Council Meeting minutes, interview with Family Council President and Administrator. [s. 85. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

The licensee has failed to ensure that when drugs were destroyed, that were not controlled substances, this was completed by a team which was composed of a member of the registered nursing staff and one other staff member appointed by the DOC.

The DOC acknowledged that the home did not have a record of, nor was there a formalized process for the destruction of non-controlled drugs in the home, by two staff including a registered nursing staff and another appointed staff member.
Medisystem Policy and Procedure Destruction of Discontinued/Expired Medications identified that destroyed/disposed of drugs were to be safely stored in sealed medical waste containers. That full containers were to be collected by a medical waste disposal company and documentation of each sealed container was to be recorded on the Non-Narcotic and Non-Controlled Drugs for Destruction Record.
The record required a registered staff and a second staff member document the destruction of the drugs.

Sources: Review of Medisystem Policy and Procedure Destruction of Discontinued/Expired Medications, 21.4.1-2 and interview with the DOC and other staff. [s. 136. (3) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

The licensee has failed to ensure that the quality improvement and utilization review system required under section 84 of the Act complied with the following requirements: 1. There must be a written description of the system that included its goals and objectives.

At the time of the inspection the licensee completed the Long Term Care Home (LTCH) Licensee Confirmation Checklist Quality Improvement and Required Programs form which was part of the Entrance Conference on the first day of the inspection. The completed form did not have a written description of the system that included its goals and objectives. The Administrator confirmed that there was a quality program in place but they did not have written goals and objectives.

Sources: (LTCH) Licensee Confirmation Checklist Quality Improvement and Required Programs and interview with Administrator. [s. 228. 1.]

Issued on this 8th day of March, 2022

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

Original report signed by the inspector.