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
Mar 06, 2020	2020_740621_0004 (A1)	022426-19, 024338-19, 000993-20	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Maple View of Sault Ste. Marie
650 Northern Avenue SAULT STE. MARIE ON P6B 6G3

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

Amended by TRACY MUCHMAKER (690) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

An extension to compliance order #001 is granted to allow the home to achieve sustainable compliance. CDD date changed from April 10, 2020, to April 13, 2020.

Issued on this 6 th day of March, 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

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

Amended by TRACY MUCHMAKER (690) - (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 3 - 7, 2020.

The following intakes were inspected during this Complaint inspection:

- Two intakes related to personal care and nutrition/hydration management; and

- One intake related to wound care management.

A Follow Up inspection (#2020_740621_0003) and Critical Incident System (CIS) inspection (#2020_740621_0005), were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Food Services Manager (FSM), Food Services Supervisor (FSS), an Acting Director of Care (ADOC), the home's Wound Care Champion, Maintenance Manager (MM), the Registered Dietitian (RD), a Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Cooks, Dietary Aides, a Housekeeping Aide and residents.

The Inspector(s) also reviewed relevant resident health care records, as well as specific licensee policies, procedures, and programs.

The following Inspection Protocols were used during this inspection:

Nutrition and Hydration
Personal Support Services
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 has failed to ensure that, where Ontario Regulation (O. Reg.) 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 68 (2) (a), the licensee was required to have written policies and procedures developed and implemented for nutrition care, dietary services and hydration, and (b) to ensure a system was in place to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

A complaint was received by the Director on a day in November 2019, alleging improper care of resident #002, which resulted in hospitalization of the resident for treatment of a specific medical condition.

During an interview with the complainant, they reported to Inspector #621 that they were concerned that staff were not monitoring and communicating changes that occurred with the resident's daily fluid intake; and that if the resident was exhibiting specific characteristics, staff were not considering contributing factors.

During an interview with the home's Registered Dietitian (RD), they reported that they assessed a resident's nutrition and hydration goals on admission, quarterly, or sooner, if there were significant changes identified. The RD indicated that a resident's fluid goal was recorded in the resident's electronic health care record, under the physician's orders section, as per direction received from Extendicare consultants more than a year ago. The RD indicated that the resident's fluid goal used to be documented on a paper food and fluid record, but documentation of this information transitioned onto the electronic health care record within the past

year. The RD identified that resident #002's daily fluid intake goal was a specified amount, and that they assessed the resident to be meeting their fluid goals, as part of their quarterly review completed on a day October 2019. According to the RD's records, the resident was not assessed again until a specific day in December 2019, when the resident's change in condition triggered a nutrition status assessment. The RD indicated that at this time, the hydration program was not active in the home.

During a review of resident #002's electronic health care record for a specific time period during November 2019 (as provided by ADOC #103), Inspector #621 identified that for a specified number of days leading up to resident #002's transfer to hospital, half of those days, fluid intake was less than the resident's assessed goal.

On review of resident #002's electronic health record, the Inspector found no documentation for a specified period of time in November 2019, of the resident's fluid intake was monitored, that monitoring identified fluid intake to be less than goal intake for the identified dates, nor any information on what actions were taken to try and improve intake, and the resident's response.

During an interview with RPN #119, they reported that a resident fluid requirement was found in Point Click Care (PCC) under the physician's orders. They reported that an order was recorded on a particular day in February 2018, for a specified fluid requirement for resident #002. RPN #119 identified that PSW staff recorded residents' fluid intake on flow sheets, located in Point of Care (POC). Further, they indicated that RPNs on nights used to complete a 24-hour fluid tally on each resident from their assigned home area, but was unsure if these calculations were being done. RPN #119 reported that the last time they themselves completed a 24-hour fluid intake tally was when the home completed this task using the paper-based food and fluid record. Further, they stated that when the home changed over to documenting food and fluid intakes in PCC, they were not sure if the system automatically flagged a fluid intake that was less than the goal, or if it had to be completed manually. The RPN stated that when assessing a resident's hydration status, they just completed a visual observation of the resident and used their clinical judgement, if an issue was identified.

During an interview with RN #130, they identified on a particular shift, during a certain day in November 2019, they notified the SDM of resident #002's change in condition. They stated to the Inspector that at the time of the incident, they were

not aware of, or alerted to, a potential hydration issue.

During an interview with RPN #142, they reported to Inspector #621 that they worked as an RPN on night shifts and they had never completed fluid intake calculations to monitor a resident's hydration. They reported that they would expect PSW staff to notify them when a resident was not drinking well on their shift, or that there was documentation to alert them of an issue.

During an interview with RPN #137, they reported to the Inspector that they worked as a night shift RPN. They identified that over the previous nine to ten months, the home had stopped monitoring resident fluid intake records and completing the daily fluid intake calculations, but that they were unclear as to the reason why. They identified that about one week ago, they noticed information at the nursing station from ADOC #103, which identified how to complete a new process for fluid monitoring. RPN #137 indicated that they were informed that ADOC #103 would be completing education on the new process with them over the next couple weeks.

On review of the home's policy from Extendicare titled "Food and Fluid Intake Monitoring, RC-18-01-01", last updated December 2019, it identified that each resident's food and fluid intake would be monitored as an ongoing indicator of nutritional and hydration status, and individually assessed for significant intake changes. Corrective actions would be taken and outcomes evaluated for identified resident intake concerns. Further, under procedures for fluid intake monitoring, the policy identified
that the nurse/interdisciplinary team would review the fluid intake records daily, and compare to the individualized fluid target, as assessed by the Registered Dietitian/designate.

During an interview with the ADOC #103, they reported to Inspector #621 that in follow up with resident #002's family following the incident in November 2019, they identified that staff were normalizing the resident's change in behavior, and not assessing further. They reported that it appeared the resident had a specified change in behaviours, for an extended period of time; there had been decreased fluid intake prior to their transfer to hospital, and that hydration assessments were not being completed. They reported that there are no alerts generated by PCC when resident fluid intakes are less than goal, and that night shift RPN's were expected to complete fluid calculations manually. ADOC #103 further stated that there was no evidence that night shift RPN's were completing the required

hydration calculations to determine if resident #002 was meeting their fluid goal or not. They identified that education was being provided to staff regarding how to monitor resident fluid intakes going forward. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 001 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# 001

WN #2: 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).

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 has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to resident #002.

A complaint was received by the Director on a day in November 2019, alleging improper care of resident #002, resulting in a significant change in condition.

During an interview with the complainant, they reported to Inspector #621 that the resident routinely complained of the temperature in a particular area of the home, that there was information posted to alert staff to keep the temperature in a specific location, at a certain level. The complainant however, identified that during visits with the resident, they observed temperature readings not consistent with information provided.

During an observation of a certain location of the home on a day in February 2020, the Inspector identified a note posted, which indicated that the area was to be kept at a certain temperature level. However, the Inspector noted that the

thermostat for that area measured a specific reading that was a particular number of degrees Celsius (°C) different than what the posted information identified.

During an interview with Housekeeping Aide (HA) #140, they reported that the family of resident #002 wanted the identified area to be kept at a certain temperature, observed the thermostat reading with the Inspector, and confirmed that it registered a reading of that was different than the requested temperature. HA #140 then proceeded to move the thermostat to another position and reported that the thermostat had probably been adjusted by staff.

During an observation of resident #002 in a particular area of the home on another day in February 2020, the resident had a change in behavior after the Inspector asked a question about the area temperature. RPN #141 followed up with the resident, who provided the same response as was provided to the Inspector when asked about the area temperature. Upon checking the thermostat, RPN #141 confirmed that it read a certain temperature, but that the note posted read that the temperature was to be at a different level.

Together with the Inspector, RPN #141 also reviewed resident #002's most current care plan, and found an intervention under a particular focus, which identified that staff were to maintain a particular environmental temperature, and to not permit the temperature to go to a certain specific temperature, for an extended period of time. Further, in the resident's care plan, under another foci, it documented that staff were to ensure that the temperature in a certain home area was always at a certain level, as per the family's request. RPN #141 confirmed that at the time of inspection, that between the two sections of the care plan, and the posted note in the resident's room, the resident's plan of care provided unclear direction to staff and others providing care to resident #002 as to what the thermostat temperature, in the specified area, was to be maintained at. RPN #141 further reported that PSW staff were to review resident care plans at the start of their shift, and report any changes required to the RPN on duty, so that the RPN could follow up with the family and make the required changes.

During an interview Maintenance Manager (MM) #129, they reported that their department staff monitored the ambient temperature readings in certain areas of the home. However, MM #129 identified that their department did not audit temperatures in the specified area, as staff including the PSWs and registered nursing staff were responsible for monitoring temperatures in these areas. Further, MM #129 reported that they were alerted to an issue that morning and a

maintenance worker was purchasing a locked cover for the identified thermostat. They indicated that the RN on duty would have the key, and would be the only staff able to unlock the thermostat and adjust the temperature thereafter. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out on the plan of care was provided to resident #002, as specified in the plan.

A complaint was received by the Director on a specific day in November 2019, alleging improper care of resident #002.

During an interview with the complainant, they reported to Inspector #621 that the resident was to be provided their fluids using a specific adaptive device, and that on their visits to the home, they found that staff were not applying this intervention consistently.

During an observation made during a particular date and time in February 2020, Inspector #621 found in a certain location of the home, a volume of fluid in a regular cup with a straw for resident #002. On further observation made during another date and time in February 2020, the Inspector noted another volume of fluid in a regular cup with a straw for the resident. Furthermore, it was noted that there was information posted in a specified location, which read that all drinks were to be given using a specific adaptive device.

On review of resident #002's most current care plan, last updated in December 2019, it identified under a particular focus that the resident was to be provided fluids using a specific adaptive device, and that the resident required a specified level of assistance. Further, on review of another area of the resident’s plan of care, last updated on a day in February 2020, it identified that the resident was to be provided fluids in a specified adaptive device, with another particular adaptive device not to be utilized.

During an interview with PSW #131, they reported to the Inspector that resident #002 was to always be provided fluids in a particular adaptive device, with a straw, as that was how the SDM wanted fluids provided to the resident. PSW #131 also reported that dietary staff sent up the resident’s nutrition supplement in a regular cup, and not in the specified adaptive device.

During further observation of the resident during a specific time on another day in

February 2020, the Inspector observed the resident offered a specific type of nutrition supplement and another fluid, using regular glassware and a straw. Midway through observation, RPN #133 obtained the only clean adaptive device remaining in the area and poured the remainder of one of the two beverages designated for resident #002.

On further review of resident #002's plan of care, Inspector #621 noted that the nutrition supplement for that particular observation period, was to be one particular type. However, unit staff reported that only another type of nutrition supplement was ever provided by the dietary department for this resident.

During an interview with RN #130, they reported that the staff were utilizing straws with fluids for this resident for a particular length of time, that the SDM wanted use of a straw with fluids, and that fluids were to be provided to the resident using a specific adaptive device. The RN reviewed the resident's care plan with a particular focus, and the resident's diet list with the Inspector, and confirmed that the diet list identified staff were not to use a particular adaptive device with the resident, and that there was nothing to verify that the SDM now wanted the use of this additional adaptive device. RN #130 reported that registered staff would have to follow up with the SDM before a change to the diet list could be made by the Food Services Manager or Registered Dietitian.

During an interview with RPN #133, they confirmed with the Inspector that the resident was offered fluids using a straw, that a specific adaptive device was to be used with all fluids, that food services only provided a certain flavor of nutrition supplement, that dietary staff provided the resident's nutrition supplement in a regular glass instead of the adaptive device, and that there were not enough of the adaptive devices on the unit to accommodate having every fluid given to the resident in this manner. On review of the resident's most current care plan with a particular focus, as well as another area of their plan of care, RPN #133 confirmed that the resident's plan of care still identified that a particular adaptive device was not to be used with this resident, that another specific type of adaptive device was to be used with all fluids provided to this resident, and the flavor type of nutrition supplement provided was not consistent with what was identified. Consequently, RPN #133 identified that care provided to resident #002 for the identified issues was not being provided as per their plan of care.

During an interview with Food Services Manager #105, they confirmed with the Inspector that there had been no report from registered staff on the unit that

resident #002's diet list required updating to remove the notation that a particular adaptive device was not to be used, and that the last update had been made on a specific day in December 2019. Further, FSM #105 confirmed that another specific adaptive device was to be used with all fluids provided to this resident since a certain date in November 2019, as per SDM request. Lastly, FSM #105 confirmed that food services staff were still providing the prescribed nutrition supplement in regular cups instead of the specified adaptive device, and that only one flavor of the specified nutrition supplement was being provided to the resident in spite of what was documented in the resident's plan of care. Consequently, FSM #105 verified that care in the identified areas was not being provided to the resident, as per their plan of care. [s. 6. (7)]

3. The licensee has failed to ensure that the care set out on the plan of care was provided to resident #001 as specified in the plan.

A complaint was received by the Director on a day in December 2019, which identified that menu items provided on an earlier day in December 2019, were not consistent with the resident's individualized planned menu.

During an interview with the complainant, they reported to Inspector #621, that in addition to the December 2019, incident there was a further incident in January 2020, when the resident was served a specific texture modified menu item, that was different than the planned menu.

During an interview with PSW #109, PSW #110 and RPN #111, they reported to the Inspector that resident #001 had an individualized menu developed for a specified reason, and that menu was kept a certain area for dietary staff reference. Further they reported that they were all working during the day of the incident in December 2019, when resident #001 was served a different specified entrée item than what had been listed on the resident's planned menu.

On review of resident #001's care plan with a specific focus, it identified that the resident received a personalized menu, for a specified reason. Further, the care plan and the resident diet list, last updated in February 2020, indicated the resident required additional items including an adaptive utensil and a particular food accompaniment, as per SDM request.

During observation of a particular meal service on a day in February 2020, the Inspector noted that there the identified food accompaniment was not served with

the resident's meal, nor was the identified adaptive utensil used to feed the resident.

During interviews with PSW #109, PSW #110 and RPN #111, they reported that the resident did not use the specified adaptive utensil, and had never seen them available on the unit for use. On review of the resident diet list, PSW #110 confirmed that the use of an adaptive utensil was listed, and thus, part of resident #001's plan of care. RPN #111 confirmed that at the time of inspection, care had not been provided as per the resident's plan of care.

During an interview with Dietary Aide #108, they reviewed the diet list for resident #001 and confirmed that a particular food accompaniment was documented to be served with the meal, and that they had spoken with the Food Services Manager, who identified that it had been an oversight and would be rectified.

During an interview with Dietary Aide #127, they reported that, concerning the incident from December 2019, Cook #128 had prepared a particular main entree for resident #001's meal which was not the same as what was on their planned menu.

During an interview with Cook #128, they reported to the Inspector that they prepared a texture modified meal consistent with the home's main menu on the day of the incident and did not send up the menu items consistent with the resident's individualized menu. Cook #128 further identified that, at the time of the incident, the home's main menu had changed over to the Fall/Winter menu cycle, but revisions to resident #001's menu had not occurred, so cooking staff just "winged it".

During an interview with Cook #107, they reported that there had been one day in January 2020, where they had worked as the cook and had sent up the specific menu item from the main menu, instead of what was posted on resident #001's menu.

During an interview with FSM #105, they confirmed with Inspector #621 that for the incident identified on a specified date in December 2019, Cook #128 had prepared and provided a particular entrée from the main menu, instead of the menu items that were identified on resident #001's planned menu. FSM #105 identified that Cook #128 reported to them that they felt it was an appropriate substitute. Further, FSM #105 confirmed that for a specific meal on a certain day

in January 2020, Cook #107 provided a specific menu option that was not consistent with resident #001's planned menu. Consequently, FSM #105 confirmed that the planned menu for resident #001 for both of the identified incidents had not been prepared and provided to the resident as specified in their plan of care. [s. 6. (7)]

4. The licensee has failed to ensure that resident #001 was reassessed and that the plan of care was reviewed at least every six months, and at any other time when the resident's care needs changed, or care set out in the plan was no longer necessary.

A complaint was received by the Director on a day in December 2019, which identified that menu items provided on an earlier day in December 2019, were not consistent with the resident's individualized planned menu.

During an interview with the complainant, they reported to Inspector #621, that in addition to the December 2019, incident there was a further incident in January 2020, when the resident was served a specific texture modified menu different than the planned menu. Further, the complainant identified that the resident's individualized menu had not been updated to be in sync with the main menu of the home for more than a year.

During an interview with FSM #105, they reported to Inspector #621 that an individualized menu had been created in consultation with resident #001's substitute decision maker (SDM) and implemented on a day in September 2018, to mitigate the risk of the resident receiving menu items containing certain ingredients. They identified that there had not been a review and revision to this resident's individualized menu, as part of their plan of care, until a specific date in January 2020, 16 months later. FSM #105 confirmed that the resident's individualized menu should have been updated at least every six months, or sooner, if there were required changes for this resident, and to coincide with implementation of the main corporate cycle menu. [s. 6. (10) (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 there is a written plan of care for each resident that set out clear directions to staff and others who provide direct care to resident #002; to ensure that the care set out on the plan of care is provided to resident #001 and #002, as specified in the plan; and to ensure that resident #001 is reassessed and that plan of care is reviewed at least every six months, and at any other time when the resident's care needs change, or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (iv) was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A complaint was submitted to the Director on January 16, 2020, outlining concerns regarding resident #009's altered skin integrity.

Inspector #542 completed a review of resident #009's health care record, which identified progress notes and a particular skin assessment, that resident #009 sustained altered skin integrity on a day in April 2019, of unknown origin. A review of the remaining weekly assessments documented, it was identified that a specified number of weekly skin assessments were not completed between particular dates in November 2019 and January 2020.

Inspector #542 interviewed the Wound Care Champion, RPN #123, who verified that the identified weekly skin assessments were not completed.

Inspector #542 received a copy the home's Skin and Wound Program and Wound Care Management policies, dated February, 2017 and December, 2019, respectively. Both policies indicated that the nurse/wound care lead would re-assess the resident at a minimum of every seven days, and complete the skin assessment tool at a minimum of seven days. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods; O. Reg. 79/10, s. 72 (2).
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable; O. Reg. 79/10, s. 72 (2).
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).
(e) menu substitutions that are comparable to the planned menu; O. Reg. 79/10, s. 72 (2).
(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the food production system provided at minimum for: (d) preparation of all menu items according to the planned menu for resident #001; (e) communication to the resident and staff of any menu substitutions; and (d) documentation on the production sheet of any menu substitutions.

A complaint was received by the Director on a day in December 2019, which identified that menu items provided on an earlier day in December 2019, were not

consistent with the resident's individualized planned menu.

During an interview with the complainant, they reported to Inspector #621, that in addition to the December 2019, incident there was a further incident in January 2020, when the resident was served a specific texture modified menu item, different than the planned menu.

On review of resident #001's care plan, including their diet list, it identified that the resident received a personalized menu developed in conjunction with the resident's substitute decision maker (SDM), to provide planned food items that were void of certain ingredients.

During an interview with Dietary Aide #127, they reported that concerning the incident from December 2019, Cook #128 had prepared a particular main entree for resident #001's meal which was not the same as what was on their planned menu.

During an interview with Cook #128, they reported to the Inspector that they prepared a texture modified meal consistent with the home's main menu on the day of the incident and did not send up the menu items consistent with the resident's individualized menu. Cook #128 further identified that, at the time of the incident, the home's main menu had changed over to the Fall/Winter menu cycle, but revisions to resident #001's menu had not occurred, so cooking staff just "winged it".

During an interview with Cook #107, they reported that there had been one day in January 2020, where they had worked as the cook and had sent up a specific menu item from the main menu, instead of what was posted on resident #001's menu.

During an interview with FSM #105, they reported to the Inspector that resident #001 had an individualized planned menu, which was developed in consultation with the SDM back in September 2018, and then updated to be consistent with the home's Fall/Winter cycle menu, on a particular date in January 2020. FSM #105 confirmed that they were aware of both incidents, and that identified menu items for the December 2019 and January 2020 incidents, had not been prepared according to resident #001's planned menu, and should have been.

When the Inspector inquired whether menu substitutions made during these

incidents for resident #001 were communicated to the resident and unit staff prior to the start of service, FSM #105 reported that they had not been communicated. Additionally, when the Inspector inquired if there was documentation kept on the kitchen's production sheets regarding any menu substitutions made to resident #001's planned menu, FSM #105 confirmed that the process of documenting menu substitutions made regarding resident #001's planned menu were not in place. [s. 72. (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 the food production system provides at minimum for: (d) preparation of all menu items according to the planned menu for resident #001; (e) communication to the resident and staff of any menu substitutions; and (d) documentation on the production sheet of any menu substitutions, to be implemented voluntarily.

Issued on this 6 th day of March, 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

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 TRACY MUCHMAKER (690) - (A1)
Inspection No. / No de l'inspection :	2020_740621_0004 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	022426-19, 024338-19, 000993-20 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 06, 2020(A1)
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Maple View of Sault Ste. Marie 650 Northern Avenue, SAULT STE. MARIE, ON, P6B-6G3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jane Freeman

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

(A1)
The licensee must be compliant with s. 8. (1) of Ontario Regulation (O. Reg.) 79/10.

Specifically, the licensee must:

(a) Ensure Registered Nursing staff are compliant with the home's policy "Food and Fluid Intake Monitoring, RC-18-01-01", as part of the home's hydration program;

b) Provide training to all Registered Nursing staff on daily fluid intake monitoring and documentation procedures, of all residents, consistent with the home's policy, by March 27, 2020. The home is to keep a record of who completed the training, the date of the training, who provided the training, and what the training entailed; and

c) Complete randomized weekly audits of fluid intake monitoring and documentation completed by Registered Nursing staff, to ensure consistent application of the home's policy.

Grounds / Motifs :

1. The licensee has failed to ensure that, where Ontario Regulation (O. Reg.) 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 68 (2) (a), the licensee was required to have written policies and procedures developed and implemented for nutrition care, dietary services and hydration, and (b) to ensure a system was in place to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

A complaint was received by the Director on a day in November 2019, alleging improper care of resident #002, which resulted in hospitalization of the resident for treatment of a specific medical condition.

During an interview with the complainant, they reported to Inspector #621 that they were concerned that staff were not monitoring and communicating changes that occurred with the resident's daily fluid intake; and that if the resident was exhibiting a specific characteristic, staff were not considering contributing factors.

During an interview with the home's Registered Dietitian (RD), they reported that they assessed a resident's nutrition and hydration goals on admission, quarterly, or sooner, if there were significant changes identified. The RD indicated that a resident's fluid goal was recorded in the resident's electronic health care record, under the physician's orders section, as per direction received from Extendicare consultants more than a year ago. The RD indicated that the resident's fluid goal used to be documented on a paper food and fluid record, but documentation of this information transitioned onto the electronic health care record within the past year. The RD identified that resident #002's daily fluid intake goal was a specified amount, and that they assessed the resident to be meeting their fluid goals, as part of their quarterly review completed on a day October 2019. According to the RD's records, the resident was not assessed again until a specific day in December 2019, when the resident's change in condition triggered a nutrition status assessment. The RD indicated that at this time, the hydration program was not active in the home.

During a review of resident #002's electronic health care record for a specific time period during November 2019 (as provided by ADOC #103), Inspector #621 identified that for a specified number of days leading up to resident #002's transfer to

hospital, half of those days, fluid intake was less than the resident's assessed goal.

On review of resident #002's electronic health record, the Inspector found no documentation for a specified period of time in November 2019, of the resident's fluid intake was monitored, that monitoring identified fluid intake to be less than goal intake for the identified dates, nor any information on what actions were taken to try and improve intake, and the resident's response.

During an interview with RPN #119, they reported that a resident fluid requirement was found in Point Click Care (PCC) under the physician's orders. They reported that an order was recorded on a particular day in February 2018, for a specified fluid requirement for resident #002. RPN #119 identified that PSW staff recorded residents' fluid intake on flow sheets, located in Point of Care (POC). Further, they indicated that RPNs on nights used to complete a 24-hour fluid tally on each resident from their assigned home area, but was unsure if these calculations were being done. RPN #119 reported that the last time they themselves completed a 24-hour fluid intake tally was when the home completed this task using the paper-based food and fluid record. Further, they stated that when the home changed over to documenting food and fluid intakes in PCC, they were not sure if the system automatically flagged a fluid intake that was less than the goal, or if it had to be completed manually. The RPN stated that when assessing a resident's hydration status, they just completed a visual observation of the resident and used their clinical judgement, if an issue was identified.

During an interview with RN #130, they identified on a particular shift, during a certain day in November 2019, they notified the SDM of resident #002's change in condition. They stated to the Inspector that at the time of the incident, they were not aware of, or alerted to, a potential hydration issue.

During an interview with RPN #142, they reported to Inspector #621 that they worked as an RPN on night shifts, and they had never completed fluid intake calculations to monitor a resident's hydration. They reported that they would expect PSW staff to notify them when a resident was not drinking well on their shift, or that there was documentation to alert them of an issue.

During an interview with RPN #137, they reported to the Inspector that they worked as a night shift RPN. They identified that over the previous nine to ten months, the

home had stopped monitoring resident fluid intake records and completing the daily fluid intake calculations, but that they were unclear as to the reason why. They identified that about one week ago, they noticed information at the nursing station from ADOC #103, which identified how to complete a new process for fluid monitoring. RPN #137 indicated that they were informed that ADOC #103 would be completing education on the new process with them over the next couple weeks.

On review of the home's policy from Extendicare titled "Food and Fluid Intake Monitoring, RC-18-01-01", last updated December 2019, it identified that each resident's food and fluid intake would be monitored as an ongoing indicator of nutritional and hydration status, and individually assessed for significant intake changes. Corrective actions would be taken and outcomes evaluated for identified resident intake concerns. Further, under procedures for fluid intake monitoring, the policy identified
that the nurse/interdisciplinary team would review the fluid intake records daily, and compare to the individualized fluid target, as assessed by the Registered Dietitian/designate.

During an interview with the ADOC #103, they reported to Inspector #621 that in follow up with resident #002's family following the incident in November 2019, they identified that staff were normalizing the resident's change in behavior, and not assessing further. They reported that it appeared the resident had a specified change in behaviours, for an extended period of time; there had been decreased fluid intake prior to their transfer to hospital, and that hydration assessments were not being completed. They reported that there are no alerts generated by PCC when resident fluid intakes are less than goal, and that night shift RPN's were expected to complete fluid calculations manually. ADOC #103 further stated that there was no evidence that night shift RPN's were completing the required hydration calculations to determine if resident #002 was meeting their fluid goal or not. They identified that education was being provided to staff regarding how to monitor resident fluid intakes going forward. [s. 8 (1)]

The severity of the issue was determined to be level 3, as there was actual harm to the resident inspected. The scope of the issue was a level 1, as the non-compliance was isolated to one resident. The home had a level 3 compliance history, as it had previous non-compliance with the same subsection of the Ontario Regulation 79/10 (O. Reg 79/10), within the previous 36 months as follows:

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

- a WN was issued on April 15, 2019, under inspection report #2019_680687_0006; and
- a VPC was issued on August 17, 2017, under inspection report #2017_655679_0004. (621)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 13, 2020(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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.

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 6 th day of March, 2020 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by TRACY MUCHMAKER (690) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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Ordre(s) de l'inspecteur

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