Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 28, 2015	2015_339617_0018	019981-15, 021893-15	Complaint

Licensee/Titulaire de permis

AUTUMNWOOD MATURE LIFESTYLE COMMUNITIES INC.
130 ELM STREET SUDBURY ON P3C 1T6

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

CEDARWOOD LODGE
860 GREAT NORTHERN ROAD SAULT STE. MARIE ON P6A 5K7

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

SHEILA CLARK (617)

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): August 19, 20, 21, 2015

A concurrent Critical Incident inspection #2015_339617_0017 was also conducted during this inspection.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Office Manager (OM), Program Manager (PM), Registered Nurses, (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aide (DA), residents and families.

The inspector also conducted a tour of the home, observed resident care, and reviewed resident health care records and certain policies of the home.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Reporting and Complaints
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **4 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	Legendé 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. (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 failed to ensure that the care set out in the plan of care for a resident was provided to resident #002 as specified in the plan.

A complaint was submitted to the director regarding the declining health condition of resident #002 since admission to the home.

Inspector #617 reviewed the health care records for resident #002 which indicated attendance to the local hospital for scheduled treatments to manage their disease process. The health care records indicated that shortly after admission to the home the resident was sent to the emergency department on two separate occasions for exacerbation of their disease process and declining health status.

On August 19, 2015, inspector #617 interviewed the complainant who reported that the resident consistently presented to the treatment sessions at the hospital in an exacerbated condition.

Inspector #617 reviewed the health care records for resident #002 which indicated that a nutritional assessment was completed by the Registered Dietitian (RD). It identified an order from the RD that specific nutritional care was to be provided to resident #002. Inspector #617 reviewed the care plan for resident #002 which set out the specific nutritional care in accordance with the RD's order.

On August 20, 2015, inspector #617 interviewed the Substitute Decision Maker (SDM) for resident #002 who reported that they observed the staff provide nutritional care that was inconsistent with the resident's needs on several different occasions.

On August 20, 2015, inspector #617 observed the procedure that staff followed in providing specific nutritional care to the residents during the lunch meal service. The specific information that resident #002 required for staff to follow was missing from the procedure as confirmed by both S #110 and S #109. Inspector #617 interviewed S #109 who reported that they were not aware that the resident was to be provided specific nutritional care and would follow the procedure which was missing the relevant information for resident #002.

Inspector #617 reviewed the nutritional record for resident #002 which confirmed that the resident did not receive their specific nutritional care required to reduce their health care risk.

Inspector #617 interviewed S #107 who reviewed the nutritional record for resident #002 and they confirmed that the resident did not receive their specific nutritional care.

The plan of care for the resident set out a plan to maintain safe nutritional care needs however, the home failed to follow the plan and placed the resident at health risk.

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 care set out in the plan of care for resident #002 is provided as specified in the plan especially related to nutritional care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that was on at all times.

On August 20, 2015, inspector #617 interviewed the Substitute Decision Maker (SDM) for resident #002 who reported that they were unsure that the call bell system worked in the home due to the lengthy response time from the staff.

On Aug 20, 2015, at 1122hrs, inspector #617 walked up to the nursing station where both S #105 and S #106 were sitting. Inspector #617 activated the call bell in a resident's room at 1124hrs. Inspector #617 waited for staff to respond to the call bell in the room and staff did not respond. At 1137hrs inspector #617 walked out of the resident's room to the nursing station where both S #105 and S #106 remained. Inspector #617 inquired as to why they did not attend the alarm. It was at that time both staff members realized that their pagers were not turned on. After S #106 turned their assigned pager on, the alarm sounded and many other room numbers illuminated on the pager display screen.

S #107 returned to the unit after their break off of the unit. They reported that during their break, their pager was alarming with the room number that the inspector tested the call bell in and showed inspector #617 that room number displayed on the screen of the pager.

Both S #105 and S #106 reported to inspector #617 that their shift started at 0700hrs on August 20, 2015, and their pagers did not alarm until they were turned on at 1137hrs. Therefore they were not aware of any call bells activated during this time and would not be able to respond to the residents' needs.

Inspector #617 interviewed S #105, S #106 and S #107 who all confirmed that the home had five pagers that were assigned at the beginning of shift. When a resident activated an alarm either in their room or the bathroom, all five pagers would alarm with a sound or buzzer and illuminated the room number on the pager.

On August 20, 2015, inspector #617 brought to the attention of the ED that two pagers were turned off between 0700hrs and 1137hrs. The ED reported that it is the expectation of the home that all pagers were left on at all times to respond to the resident's needs. [s. 17. (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 to ensure that the home is equipped with a resident-staff communication and response system that will remain on at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written hot weather related illness prevention and management plan for the home that met the needs of the residents was implemented when required to address the adverse effects on residents related to heat.

Inspector #617 reviewed multiple complaints submitted to the director and followed up with the complainants which identified a concern with the lack of air conditioning in the resident care area of the home and the hot environment for the residents during hot weather.

On August 20, 2015, Inspector #617 toured the home with S #103, manager of the building maintenance, who confirmed that the home did not have central air conditioning. S #103 identified that there was only one cooled area, the dining room, which was connected to the resident care area by a corridor. The care area did not have a cooling system.

Inspector #617 reviewed the Hot Weather Management of Resident Risk policy #VII-G-10.10 last updated on January 2015, indicated that there were three levels of interventions put into place when the threshold temperature and humidity readings are reached:
Maintenance was responsible to record indoor temperature, humidity percentage from various locations within the building daily, and document temperatures on the electronic computerized maintenance system or "Air Temperature Log". Maintenance was to inform all departments of the Heat Contingency protocols to be implemented. The DOC was to ensure that there is a system to readily identify each resident's hydration risk level.

On August 20, 2015, at 1327hrs, inspector #617 observed in the dining room a thermostat reading of 22 degrees Celsius. The air in the dining room was less humid that the air in the care areas which is separated by a long corridor from the dining room. Inspector #617 observed staff members who had sweat on their foreheads and collars while providing care to residents in the care area. Inspector #617 observed residents wearing light clothing and wore cool cloths on their forehead to aid in reducing their body heat. The majority of the windows in residents' rooms were open. There was no sun that day and all curtains were open. Inspector #617 observed a resident sleeping most of the day in their wheelchair in their room. The Substitute Decision Maker (SDM) for that resident was in the room and reported that it was too humid in the care area as a result the resident would sleep all day.

Inspector #617 interviewed the ED who confirmed that the home currently isn't taking temperature and humidity readings per the home's Hot Weather Management of Resident Risk policy #VII-G-10.10, which would determine the need for instituting the interventions in the hot weather policy.

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 written hot weather related illness prevention and management plan for the home that meets the needs of the residents is implemented when required to address the adverse effects on residents related to heat, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and this Regulation.

Inspector #617 reviewed multiple complaints regarding insufficient staffing in the home. Inspector #617 followed up with three complainants who reported that the home was chronically under staffed especially during the evening shifts. During the course of the inspection, inspector #617 received several complaints from residents, family and staff regarding insufficient staffing of PSWs.

The home's staffing plan was provided to inspector #617 by the ED and the DOC on August 20, 2015. Inspector #617 reviewed the staffing plan and identified that the planned deployment of direct care staff was frequently not met. The following was the planned staffing mix for the single leveled care area currently at a capacity of 36 residents:

PSWs: 5 on day (D) shift; 4 on (E) evening shift; 2 on night (N) shift (shifts are 7.5hrs)
RPNs: 1 on day (D) shift; 1 on (E) evening shift (shifts are 7.5hrs)
RNs: 1 on day (D) shift and 1 on night (N) shift (shifts are 11.75hrs.

The home had a back up plan for PSW staff shortages which involved the re-assignment of an increased number of residents to the PSWs in attendance to achieve an equal work load.

On August 21, 2015, inspector #617 interviewed the ED who confirmed that there is a staffing shortage in the home and was in the process of hiring more PSWs and RPNs. The home provided to inspector #617 the schedule of attendance and payroll hours for the months of June and July to determine staffing levels. Inspector #617 reviewed the documents and determined that the following shifts were short staffed:

June:
1: 2 x PSW D, 2 x PSW E
6: 1 x PSW D
7: 2 x PSW D
9: 2 x PSW E, 1 x RN D
10: 1 x PSW D
11: 1 x PSW E
12: 1 x PSW D, 1 x RN D
13: 1 x PSW D, 1 x PSW E, 1 x RN D
14: 1 x PSW D, 1 x PSW E, 1 x RN D8
15: 2 x PSW D, 1 x PSW E
16: 1 x PSW E, 1 x RN D8
17: RN x D8
18: 1 x PSW D
19: 2 x PSW D, 1 x PSW E
20: 1 x PSW D, 2 x PSW E, 1 x RN N
21: 1 x PSW D, 1 x PSW E, 1 x RPN E
22: 1 x PSW D, 1 x RN D8
23: 1 x PSW E
24: 1 x PSW D, 1 x PSW E, 1 x RN D8
25: 2 x PSW E
26: 1 x PSW E
27: 1 x PSW D, 3 x PSW E
28: 1 x PSW D, 3 x PSW E

29: 1 x PSW D
30: 1 x PSW D

July:
1: 1 x PSW E,
2: 1 x PSW D, 1 x PSW E
3: 1 x PSW E
4: 2 x PSW D, 1 x RPN D
5: 1 x PSW D
6: 1 x PSW E
11: 1 x PSW E, 1 x PSW N
12: 1 x PSW E
13: 1 x PSW E, 1 x PSW N
16: 1 x PSW E
17: 1 x PSW D, 1 x PSW E
18: 1 x PSW E, 1 x RN D
19: 1 x PSW D, 1 x PSW E
20: 1 x PSW D
21: 1 x PSW D, 1 x RN N
22: 1 x PSW D
23: 1 x PSW D
24: 1 x PSW N
25: 1 x PSW D, 2 x PSW E
26: 1 x PSW E, 1 x RN N
27: 1 x PSW E
28: 1 x PSW E
29: 1 x PSW E, 1 x RPN D
30: 1 x PSW E
31: 1 x PSW D, 1 x PSW E

On August 19, 2015, inspector #617 interviewed S #104 who reported that they work short almost every evening shift with only two PSWs on the floor and it was worse on the weekend. S #104 reported that when they worked short staffed, staff attempted to get all the residents' care completed however, if they were unable to, bathing would be a sponge bath or put off until the next day and residents would have longer wait times for care and assistance. S #104 also reported that when working short there was not enough staff to assist residents with toileting, and manage responsive behaviours. S #104 stated that resident families helped out by feeding their loved ones during lunch and dinner.

On August 20, 2015, inspector #617 interviewed the Substitute Decision Maker (SDM) for resident #002 who stated that the bathroom call bell in the resident's room, must not have been working. The resident had rung the bell when on the toilet and nobody came to assist them. The SDM reported that the resident's room mate would help transfer resident #002. Inspector #617 reviewed the call bell log sheet for the bathroom alarm in resident #002's room for the following dates and times to determine the length of time the activated bells were answered during above mentioned staffing shortages:
June 18, 2015 - activated at 1358hrs and completed at 1410hrs for a total lapse time of 11 minutes
June 19, 2015 - activated at 2117hrs and completed at 2142hrs for a total lapse time of 25 minutes
June 20, 2015 - activated at 1914hrs and completed at 1944hrs for a total lapse time of 30 minutes
June 24, 2015 - activated at 1642hrs and completed at 1957hrs for a total lapse time of 194 minutes
June 26, 2015 - activated at 1409hrs and completed at 1543hrs for a total lapse time of 93 minutes.

Inspector #617 interviewed the room mate to resident #002. The room mate reported to the inspector that they would often assist the resident to the washroom and they would sit for a long time before staff would help them off of the toilet. The room mate explained they didn't help the resident off of the toilet because it was too hard to lift them. The care plan for the resident indicated that they required the assistance of two staff for transferring.

On August 20, 2015, inspector #617 interviewed the SDM for a resident #004 who reported that on evenings the PSW staff were chronically working short and that there should have been four PSWs but there were only two on and it was worse on weekends. The residents had to wait to be fed. The SDM for resident #004 stated that they attend lunch and supper meals every day and provided assistance with feeding their loved one ensuring they didn't have to wait a long time to eat and then lose their appetite. On August 19, 20, and 21, 2015, inspector #617 observed a family member assisting the resident in the dining room for lunch and supper.

On August 19, 2015, inspector #617 interviewed the SDM for resident #001 who reported that they attended the home daily from 0900hrs to 1800hrs and provided assistance with feeding to ensure that their loved one was cared for and safe because the home was

chronically under staffed.

On August 21, 2015, during the course of the inspection, the SDM for resident #006 approached inspector #617 and reported that they attended the home from 0900hrs to 1800hrs daily to assist with feeding and ensure that care was being given to their family member. They reported that on the evening shifts there were only two PSWs when there should be four. This has happened consistently since the home opened.

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 staffing plan provided for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation, to be implemented voluntarily.

WN #5: 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 :

The licensee failed to ensure that their plan, policy, protocol, procedure, strategy or system for complaint management was complied with.

Inspector #617 reviewed the home's policy titled, "Resident Family Complaints Procedure", #XV-A-10.10, last updated on January 2015, which indicated that all

resident/family complaints would be brought to the attention of the department manager, investigated, and/or responded to within 48 hours of notification of the complaint. The General manager or designate would:
9) Investigate immediately any complaint where harm or risk of harm to one or more residents has been alleged and complete the investigation checklist.
10) Provide a written response outlining what has been done to resolve the complaint, or that the complaint is believed to be unfounded and the reasons for the belief, to all written complaints within 10 days.
13) Maintain a record of all complaints received, verbal and written, using Resident/Family issues report.
15) Record summary of follow up with resident and family regarding care issues in the progress notes or maintain a file with a written summary of all follow up action.

The home received a written complaint dated July 19, 2015, from the Substitute Decision Maker (SDM) for resident #004 regarding care and services. The Vice President of Management Services, met with complainant on July 27, 2015, to discuss concerns and review internal processes to rectify the concern. There was no record of a written response to the concerns raised by the complainant on file at the home or that the home had followed their own procedures regarding response to complainants at the time of this inspection.

On August 20, 2015, inspector #617 interviewed the SDM for resident #004 who confirmed that they did not receive a written response to their concerns that indicated what had been done to resolve their concerns or if the home believed their complaint was unfounded and the reasons for the belief.

The home received a written complaint from the SDM for resident #001 regarding care and services dated received by the home on July 23, 2015. The Vice President of Management Services attempted to meet with the complainant on July 27, 2015, to discuss concerns and review internal processes. The SDM declined two attempts at meeting offers on July 27 & 28, 2015. There was no record of a written response to the concerns raised by the complainant on file at the home or that the home had followed their own procedures regarding response to complainants at the time of this inspection.

On August 19, 2015, inspector #617 interviewed the SDM for resident #001 who confirmed that they did not receive a written response to their concerns that indicated what had been done to resolve their concerns or if the home believed their complaint was unfounded and the reasons for the belief.

Inspector #617 reviewed a written complaint submitted to the Director which was sent via email from the SDM for resident #003 regarding care and services dated on June 25, 2015, to the licensee of the home. Inspector #617 reviewed the home's documents submitted to the director dated June 29, 2015, which indicated the complainant was interviewed by telephone by a representative from corporate office, S #108, who recorded the concerns raised by the complainant. Another document submitted to the Director dated July 29, 2015, indicated that a meeting occurred with the DOC and complainant to review their concerns. The DOC sent a letter to the complainant dated August 11, 2015, in response to the concerns.

Inspector #617 interviewed SDM for resident #003 on August 21, 2015, who confirmed dates as above. The SDM for resident #003, reported that the response from the home did not address all of the specific concerns of their complaint.

The home received three written complaints regarding the care and services of residents residing in the home. The home did not follow their policy for the procedure on managing resident/family complaints. There was no evidence of an investigation for one complaint. There were no written responses to follow up for two of the complaints. All complaints were not responded to within 10 days of receipt. [s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the home received a written complaint concerning the care of a resident or the operation of the long-term care home, the home did not immediately forward it to the Director.

The home received an emailed written complaint on June 25, 2015, from the Substitute Decision Maker (SDM) for resident #003. The DOC emailed the ACTIONline to inform the director on August 6, 2015, that they had received a written complaint. The home did not notify the director immediately using the Critical Incident System (CIS) to report the receipt of a written complaint.

The home received an written complaint on July 23, 2015, from the SDM for resident #004. The VP of the home emailed the Ministry of Health and Long Term Care (MOHLTC) to inform the director on July 29, 2015, that they had received a written complaint. The home did not notify the director immediately using the CIS to report the receipt of a written complaint.

The home received a written complaint on July 23, 2015, from the SDM for resident #001. The VP of the home emailed the MOHLTC to inform the director on July 29, 2015, that they had received a written complaint.

The home did not notify the director immediately using the CIS to report the receipt of a written complaint.

Issued on this 29th day of October, 2015

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

Original report signed by the inspector.