Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: March 27, 2023

Inspection Number: 2022-1559-0001

Inspection Type:
Complaint
Critical Incident System

Licensee: Regional Municipality of Durham

Long Term Care Home and City: Hillsdale Estates, Oshawa

Lead Inspector	**Inspector Digital Signature**
Lynda Brown (111)	Lynda Brown Digitally signed by Lynda Brown Date: 2023.03.27 11:06:52 -04'00'

Additional Inspector(s)
Tiffany Forde (741746)
Elaina Tso (741750)
Diane Brown (110)

INSPECTION SUMMARY

The inspection occurred on the following date(s):
December 28-30, 2022 and January 3-6, 9- 11, 13, 16-18, 2023.

The following Complaint intake(s) were inspected:
- Intake # 00002007 related to medical care, Physician and pain management.
- Intake # 00003189 related to IPAC.
- Intake # 00008789 related to Physician, medications, and residents rights.

The following Critical Incident System (CIS) were inspected:
- Intake # 00002742 related to a fall with injury.
- Intake # 00003842 and # 00013099 related to alleged staff to resident abuse.
- Intake # 00004588 and # 00013657 related to resident-to-resident physical abuse.
- Intake # 00012012, # 00002287, # 00012056 and # 00013745 related to resident to resident responsive behaviours.
- Intake # 00013099 related to medication incidents.

The following intakes were completed in the Critical Incident System Inspection:
- Intake # 00004588 related to responsive behaviours.

The following **Inspection Protocols** were used during this inspection:

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4)(b)

The licensee has failed to ensure that staff and others involved in the different aspects of care for a resident, collaborated with each other to ensure the implementation of the plan was consistent with each other.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director related to an altercation between two residents. One of the resident's had increased pain to a specified area as a result and required increased staff assistance with mobility. The physician was notified and ordered a diagnostic test. There was no documented evidence that the diagnostic test was completed. An RN determined several months later that the diagnostic test had not been completed. There was no documented evidence that the physician was notified when the diagnostic test had not been completed as ordered. A Registered Practical Nurse (RPN) and Director of Care (DOC) also confirmed there was no record of the diagnostic test for resident #007.

Failing to ensure that the that staff and others involved in the different aspects of care for a resident, collaborated with each other, resulted in a diagnostic test not being completed as ordered.

Sources: CIR, a resident's health record, interviews with Registered staff and the DOC.
[741750]

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

1.The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with for two residents related to the alleged abuse investigation.

Rationale and Summary

A CIR was submitted to the Director related to an alleged abuse incident involving two residents. As per the home's abuse and neglect policy, the investigation lead was required to complete a summary documentation to summarize all the information from the investigation. There was no summary documentation found in their investigation file. The Assistant Director of Care (ADOC) and the Director of Care (DOC) stated they use the CIR as their summary and the ADOC further indicated that the summary documentation was not their practice.

Failing to follow the home's policy to promote zero tolerance of abuse and neglect, did not include a documented summary of the outcome of the home's investigation.

Sources: CIR, Home's Abuse and Neglect – Prevention, Reporting, and Investigation Policy, home's investigation records, interviews with the ADOC and the DOC.

[741750]

2.The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with two residents related to the abuse investigation.

Rationale and Summary

A CIR was submitted to the Director related to an alleged abuse incident involving two residents. One of the residents sustained an injury as a result. As per the home's abuse and neglect policy, the investigation lead was required to complete a summary documentation to summarize all the information from the investigation. There was no summary documentation found in their investigation file. The Assistant Director of Care (ADOC) and the Director of Care (DOC) stated that they used the CIR

as their summary. The ADOC further stated that the summary documentation was not their practice.

Failing to follow the home's policy to promote zero tolerance of abuse and neglect, did not include a documented summary of the outcome of the home's investigation.

Sources: CIR, home's Abuse and Neglect – Prevention, Reporting, and Investigation Policy, home's investigation record, interviews with the ADOC and the DOC.

[741750]

3.The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with for two residents related to an alleged abuse investigation.

Rationale and Summary

A CIR was submitted to the Director related to a second incident of alleged abuse involving two residents. Both residents sustained an injury as a result. As per the home's abuse and neglect policy, the investigation lead was required to complete a summary documentation to summarize all the information from the investigation. There was no summary documentation found in their investigation file. The Assistant Director of Care (ADOC) and the Director of Care (DOC) stated that they used the CIR as their summary. The ADOC further stated that the summary documentation was not their practice.

Failing to follow the home's policy to promote zero tolerance of abuse and neglect, did not include a documented summary of the outcome of the home's investigation.

Sources: CIR, Home's Abuse and Neglect – Prevention, Reporting, and Investigation Policy, home's investigation record, interviews with the ADOC and the DOC.

[741750]

4.The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with for two residents related to an alleged abuse investigation.

Rationale and Summary

A CIR was submitted to the Director related to a third incident of alleged abuse involving two residents. One of the residents sustained an injury as a result. As per the home's abuse and neglect policy, the investigation lead was required to complete a summary documentation to summarize all the

information from the investigation. There was no summary documentation found in their investigation file. The Assistant Director of Care (ADOC) and the Director of Care (DOC) stated that they use the CIR as their summary. The ADOC further stated that the summary documentation was not their practice.

Failing to follow the home's policy to promote zero tolerance of abuse and neglect, did not include a documented summary of the outcome of the home's investigation.

Sources: CIR, Home's Abuse and Neglect – Prevention, Reporting, and Investigation Policy, home's investigation record, interviews with the ADOC and the DOC.

[741750]

WRITTEN NOTIFICATION: Licensee Must Investigate, Respond and Act

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

The licensee failed to ensure that every alleged incident of abuse of a resident was immediately investigated.

Rationale and Summary

A CIR indicated an alleged resident to resident abuse incident occurred and was reported to an RN by a family member. The Director of care (DOC) confirmed that no formal investigation occurred for this incident. There was no documented record of the home's investigation into the alleged abuse incident.

As a result of the inaction of the home to investigate the alleged abuse incident immediately, resident #005 and other residents are at increased risk of abuse as there were no interventions put in place to prevent further abuse.

Sources: CIR, the home's investigation file, a resident's clinical records, interview with DOC
[741746]

WRITTEN NOTIFICATION: Weight Changes

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 75

The licensee has failed to ensure that the Registered Dietician (RD) for the home, completed a nutritional assessment for a resident when they had significant changes in weight.

Rationale and Summary

A CIR was submitted to the Director regarding a complaint received from the family of a resident related to nutritional status and hospitalization. There were no nutritional assessments completed on specified dates when the RD ordered a nutritional supplement for the resident. The resident continued to have weight loss over a period of time. The RD stated that nutritional assessments were not completed for the resident and acknowledged that interventions in place, were not effective for the resident. The RD stated the home's expectation was for staff to send a dietary referral when residents experience significant changes which initiates a nutritional assessment.

Failing to conduct a nutritional assessment for a resident, when they had continued weight loss, did not ensure the resident had adequate interventions to promote weight gain.

Sources: CIR, interview with an RD, a resident's clinical records.
[741746]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 58 (1) 1.

The licensee has failed to ensure that written approaches to care, including screening protocols, assessment, reassessment and identification of behavioral triggers that result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other, were developed to meet the needs of residents with a specified responsive behaviour.

Rationale and Summary

The home's Responsive Behaviour Prevention and Management Program indicated the home was to use a a specified tool, in conjunction with additional evidence-based practice assessments as required, as part of their interdisciplinary screening and assessment process. The program also included the development of a resident focused plan of care incorporating interventions and strategies specific to the resident's needs, to prevent and manage responsive behaviours. The home's program did not include any specific assessments or strategies related to residents demonstrating a specified responsive behaviour.

A resident had been demonstrating a responsive behaviour on several dates. The resident's care plan

had no indication of the responsive behaviour, triggers, or strategies to mitigate the risk to the resident. There was also no documented evidence the specified tool as required, had been completed for the resident. A Behavioural Support Ontario (BSO) staff confirmed they did not complete the specified tool for the resident but initiated a different tool. They also confirmed the responsive behaviour policy did not contain any assessment tools or procedures for managing residents with the specified responsive behaviour and was unaware the resident's care plan did not include a focus for the behaviour. A Social Worker (SW) indicated they had implemented their own assessment tools and strategies for the resident related to their specified responsive behaviour, as the home did not have any.

Failing to have written approaches to care, including screening protocols, assessments, and identification of behavioral triggers that result in responsive behaviours, were developed, specifically high-risk responsive behaviours, resulted in a resident not having a care plan to meet their needs, staff resorting to implementing their own assessments and required tools not being utilized to mitigate the risk to the resident.

Sources: CIR, Responsive Behaviour Prevention and Management Program, a resident's health record, and interviews of staff.
[111]

WRITTEN NOTIFICATION: Infection, Prevention and Control

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

1.The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented, including at minimum, Additional Precautions of the appropriate selection of additional personal protective equipment (PPE) requirements.

Rationale and Summary

IPAC Standard 9.1, Routine Practices (d)

During a tour of the home, Inspector #111 observed on a specified unit, a resident room with two residents with a PPE station hanging from their door, that only contained disinfectant wipes and hand sanitizer. On another unit, a resident had signage for specified precautions but the PPE station hanging on the resident's door, did not contain the required PPE. On another unit, a resident had signage for specified precautions but the PPE station hanging on the resident's door did not contain the required PPE. An RN from the first unit indicated the first resident room with two residents, included only one of

the residents on specified precautions and was unaware the PPE station did not contain the required PPE. Another RN indicated the other resident was on specified precautions and the PPE station should have included all required PPE. An RPN from the second unit indicated they were not aware that the PPE station for the resident did not contain the required PPE.

Failing to ensure appropriate PPE is available for residents on additional precautions places residents and staff at risk for transmission of infections.

Sources: Observations and interview of staff (Registered staff).
[111]

2.The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented, including at minimum, Additional Precautions of point-of-care signage indicating that enhanced IPAC control measures are in place.

Rationale and Summary

IPAC Standard 9.1, Additional Precautions (e)

Inspector #111 observed a number of resident rooms with PPE hanging on their door. There was no signage posted to indicate what additional precautions were in place. An RPN indicated one of the residents was on specified precautions and another resident was on a different specified precaution. They were not aware there was no signage posted. An RN indicated a resident was on specified precautions and was unaware there was no sign posted at the resident's room. A resident had a PPE station hanging on their door and the signage indicated the resident was to have PPE in place when their aerosol generating medical system (AGMP) was in use. The sign did not indicate which PPE was to be used or which type of precaution was in place when in use. An IPAC Lead indicated that any residents using an AGMP should have specified precaution signage which is only to be used when AGMP was in use. They also indicated that signage should be posted at any resident’s door based on the type of isolation precautions required and when there are PPE stations provided.

Failing to provide additional precautions of signage posted at the resident’s doorway leads to staff being unaware of which PPE they are required to don prior to providing resident care and the transmission of infection to other residents and staff.

Sources: tour of the home and interview of staff (Registered staff and IPAC lead).
[111]

WRITTEN NOTIFICATION: Infection, Prevention and Control

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (11) (a)

The licensee failed to ensure their outbreak management system policy was complied with.

Rationale and Summary

On specified dates, on a specified unit, there were several residents who were placed on isolation with similar symptoms of infection. The Nurse was to review and document any new or changes in residents including signs and symptoms of infection, to observe for any potential clusters that could suggest an outbreak and report to the Infection Prevention and Control (IPAC) practitioner immediately. The IPAC Practitioner was to review infection prevention and control notes for any signs and symptoms of infection and determine if an outbreak was in progress and then document on the Infection Control Surveillance Record Form. They were to report any concerns to the Public Health for confirmation and determination of a case definition. There was no documented evidence the suspected outbreak was reported to the Public Health Unit (PHU).

An RN indicated they record any residents with symptoms of infection in the resident's progress notes and complete a paper surveillance report that the IPAC lead picks up daily. They indicated they also send the IPAC lead an email if they suspect an outbreak. They were unable to provide the Inspector a copy of a current paper surveillance report in use. An RPN indicated they also documented an infection progress note for residents with symptoms of infection but was unaware of any paper surveillance report. The RPN indicated they also record on the 24-hour report book, those residents currently placed on isolation with infections and confirmed on the identified dates, the 24-hour report book did not have any residents identified under isolation on that unit. The PHU confirmed they had not been notified of the suspected outbreak but should have been. The IPAC Lead #116 also confirmed they had not reported the suspected outbreak to the PHU as they were unaware of the cluster of infection symptoms on that unit.

Failing to comply with the home's infection, prevention and control policy related to outbreak management and reporting suspected outbreaks in the home to the Public Health unit, could result in further transmission of infections to residents and staff.

Sources: surveillance report, progress notes for a number of residents and interviews with Registered staff, IPAC lead, and Public Health unit.
[111]

WRITTEN NOTIFICATION: Notification re: Incidents

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 104 (2)

1.The licensee has failed to ensure that the substitute decision-makers (SDMs) of two residents were notified of the results of the investigation immediately upon the completion of the investigation.

Rationale and Summary

A CIR was submitted to the Director related to an alleged abuse between two residents. The home completed the investigation but did not follow up with the SDMs for both residents with the results. There was no documentation in the progress notes or the investigation files about notifying the SDMs of the investigation results. The Director of Care (DOC) confirmed that the SDMs for both residents were not notified when the investigation was completed.

Failure to notify the SDMs for both residents of the outcome of the home's investigation, resulted in the SDMs not being aware of the outcome and actions taken to prevent a recurrence.

Sources: CIR, two resident's health records, home's investigation record, interview with the DOC. [741750]

2.The licensee has failed to ensure that the SDMs of two residents were notified of the results of the investigation immediately upon the completion of the investigation.

Rationale and Summary

A CIR was submitted to the Director related to an alleged abuse between two residents. The home completed the investigation but did not follow up with the SDMs for both residents about the investigation results. There was no documentation in the progress notes or the investigation file about notifying the SDMs of the investigation results. The ADOC also confirmed the same.

Failure to notify the SDMs for both residents of the outcome of the home's investigation, resulted in the SDMs not being aware of the outcome and actions taken to prevent a recurrence.

Sources: CIR, two resident's health records, home's investigation record, interview with the ADOC. [741750]

3.The licensee has failed to ensure that the SDM of a resident was notified of the results of the investigation immediately upon the completion of the investigation.

Rationale and Summary

A CIR was submitted to the Director related to an alleged abuse between two residents. The home completed the investigation but did not follow up with the SDM for one of the residents about the investigation results. There was no documentation in the progress notes or the investigation file about notifying the SDM of the investigation results when the investigation was completed. The ADOC confirmed the same.

Failure to notify the SDM of a resident of the outcome of the home's investigation, resulted in the SDM not being aware of the outcome and actions taken to prevent a recurrence.

Sources: CIR, a resident's health record, home's investigation record, and interview with the ADOC. [741750]

4.The licensee has failed to ensure that the SDMs for two residents were notified of the results of the investigation immediately upon the completion of the investigation.

Rationale and Summary

A CIR was submitted to the Director related to an alleged abuse between two residents. The home completed the investigation but did not follow up with the SDMs for the residents about the investigation results. There was no documentation in the progress notes or the investigation files about notifying the SDMs of the investigation results when the investigation was completed. The ADOC confirmed the same.

Failure to notify the SDMs for two residents with the outcome of the home's investigation, resulted in the SDMs not being aware of the outcome and actions taken to prevent a recurrence.

Sources: CIR, two resident's health records, home's investigation record, interview with the ADOC. [741750]

WRITTEN NOTIFICATION: Medication Incidents and Adverse Drug Reactions

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 147 (2) (a)

The licensee failed to ensure that all medication incidents involving a resident were documented, reviewed and analyzed.

Rationale and Summary

A complaint was received from the family regarding medication incidents involving a resident. The family of the resident had reported to nursing staff, two separate medication incidents. The nursing staff indicated that they would report the incidents to the Resident Care Coordinator (RCC). There was no documented evidence of a medication incident report documented, reviewed, and analyzed. The RCC indicated they could only vaguely recall one of medication incidents being reported. The DOC confirmed they did not have a documented medication incident report for the identified dates that were reported.

Failing to ensure medication incidents are documented, reviewed, and analyzed for a resident did not allow for actions to be taken to prevent a recurrence.

Sources: complaint, a resident's health record, medication incident reports and interviews with Registered staff and DOC.
[111]

WRITTEN NOTIFICATION: Pain Management

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 52 (2)

The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary

A complaint was received from the family of a resident regarding palliative care and pain management. During specified dates, the resident began receiving pain medication daily and there was no indication the physician was notified of the resident's increased complaints of pain or increased use of pain medication. During another specified period, the resident began having symptoms of an infection and continued complaints of pain to a specified area. The family expressed concerns regarding the resident's

symptoms of infection, the physician was notified, ordered increased pain medication and the resident was transferred to the hospital. The resident returned later the same day with a new prognosis. The resident continued to complain of pain and was given the previous pain medication. The Nurse Practitioner (NP) contacted the family to discuss the resident's recent prognosis and scheduled a care conference for several days later. The resident continued to complain of pain and was given pain medication that was ineffective. The resident was not offered the increased pain medication until several hours later which was effective. The resident later continued to complain of increased pain to a specified area and was given the increased pain medication with no effect. The physician was notified, and the resident was transferred back to the hospital. The resident returned later the same day and a comprehensive pain assessment was completed at that time. The resident was not deemed palliative with additional pain medications ordered, until the following day and the resident passed away a day later.

The DOC confirmed the nursing staff were required to complete a comprehensive pain assessment when the resident was having new or worsening pain, upon return from hospital or when starting new pain medication. The DOC also indicated the palliative performance scale (PPS) was to be used when a resident's condition was deteriorating to ensure they had adequate pain management. The DOC indicated if the resident's pain was not being relieved, the staff should also have notified the physician for increased analgesic. The DOC confirmed that the only pain assessment completed for the resident was a number of days before the resident died and no PPS was completed.

Failing to complete a comprehensive pain assessment or a PPS for the resident when the resident had increased and ongoing unrelieved pain, when they returned from hospital or when their condition deteriorated and became palliative, resulted in the resident having unmanaged pain.

Sources: complaint, a resident's health record and interview of DOC.
[111]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 58 (4) (a)

The licensee failed to ensure that a resident who demonstrated responsive behaviours, the behavioural triggers for the resident were identified, where possible.

Rationale and Summary

A CIR was submitted to the Director for a resident-to-resident responsive behaviour incident. One of the resident's care plans did not include the triggers for their responsive behavior. BSO staff confirmed the care plan did not identify the triggers for the residents' responsive behaviours.

Failing to identify the triggers for one of the resident's responsive behaviour results in staff being unaware of how to prevent the behaviours.

Sources: CIR, a residents health record and interviews with staff.
[741746]

WRITTEN NOTIFICATION: Altercations and Other Interactions Between Residents

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 59 (b)

The licensee has failed to ensure steps were taken to minimize the risk of altercations and potentially harmful interactions between a resident towards two residents and other residents, by identifying and implementing interventions.

Rationale and Summary

A CIR was submitted to the Director related to an altercation between two residents. One resident sustained pain and altered mobility as a result. An RPN who was working when the altercation occurred, confirmed there was no continuous monitoring in place for one of the residents when the altercation occurred, and they requested the continuous monitoring be put in place.

A second CIR was submitted to the Director several days later, related to another altercation between two residents. Both residents sustained an injury as a result. An RPN who was working when that altercation occurred, confirmed there was no continuous monitoring in place for one of the residents.

A third CIR was submitted to the Director a few weeks later, related to another altercation between two residents. One of the residents sustained an injury as a result. A BSO staff confirmed there was no continuous monitoring for one of the residents when that altercation occurred.

For several months, one of the residents had ongoing responsive behaviours and altercations towards several residents. The continuous monitoring records for that resident indicated the continuous monitoring was to be started weeks before the first altercation occurred and was to be in place 24 hours a day, seven days a week. The resident's care plan was not updated with the intervention of continuous monitoring until several days after the second altercation. One of the recipient resident's care plans also

included the use of a specified intervention to be in place to deter further altercations. An RN confirmed that the specified intervention for that resident was effective at deterring further altercations. Another BSO staff indicated the continuous monitoring of the aggressive resident was only used intermittently until after the third altercation, when it was used continuously. There was no documented evidence that when the altercations occurred, there was continuous monitoring in place for the resident. On an identified date, at various times, Inspector #741750 observed the resident with no continuous monitoring in place or the specified intervention in place for another resident. A PSW indicated the continuous monitoring was taken away from the resident for another resident.

Failing to implement the interventions of continuous monitoring for a resident and the specified intervention for another resident, continued to place residents at risk from further altercations and injuries by the resident.

Sources: three CIR's, three resident's health records, and interviews with staff.
[741750]

COMPLIANCE ORDER CO #001 Nutritional Care and Hydration Programs

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 74 (2) (d)

The licensee is to ensure compliance with FLTCA, 2021, s. 201. [FLTCA, 2021, s. 155 (1) (a)].

Specifically, the licensee shall:

1. Retrain Registered Dieticians with regards to conducting Nutritional Assessments (Nutritional status, including height, weight and any risks relating to nutritional care), specifically when adding supplements for resident with poor intakes and when residents are not meeting targeted fluid intake goals.

2. Keep a Documented record of the education, including the date it was provided and make available to the inspector upon request.

3. Complete an audit for one month, to ensure that the interventions for nutritional supplements are included in the care plans of resident.

4. Keep a Documented record of the audit, including the dates it was completed and make available to the inspector upon request.

Grounds

The licensee failed to ensure a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration was in place for a resident.

Rationale and Summary

A CIR was submitted to the Director for alleged neglect of a resident related to nutritional needs. The resident had specified daily fluid requirements and their fluid records revealed they were not meeting their daily hydration needs. The resident was hospitalized with diagnoses related to hydration. The quarterly nutritional assessments completed on specified dates both yielded the same outcomes, despite the resident not meeting their daily fluid requirements. There was no indication an RD conducted assessments or managed the resident with low fluid intakes. The RD acknowledged the resident's fluid intakes were below their requirements and continued with the same interventions. There were no additional interventions considered for the resident to meet their daily hydration goals.

Failing to monitor and evaluate a resident's hydration status and put in place a system for the resident with identified hydration risk, resulted in the resident being admitted to hospital.

Sources: CIR, a resident's health record, and interview with an RD.

[741746]

This order must be complied with by May 1, 2023.

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;

(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board

Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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