Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
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Telephone: (705) 564-3130
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 7, 2019	2019_740621_0033	004004-19, 004005-19, 004006-19	Follow up

Licensee/Titulaire de permis

Hornepayne Community Hospital
278 Front Street P.O. Box 190 HORNEPAYNE ON P0M 1Z0

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

Hornepayne Community Hospital
278 Front Street P.O. Box 190 HORNEPAYNE ON P0M 1Z0

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

JULIE KUORIKOSKI (621)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): October 29 - 31, 2019.

The following Compliance Order (CO), issued during inspection #2019_740621_0006 were inspected during this Follow Up Inspection:
- One intake, regarding CO #001, related to r.71(1)(b) of Ontario Regulation (O.Reg) 79/10;
- One intake, regarding CO #002, related to r.71(1)(e) of O.Reg 79/10; and
- One intake, regarding CO #003, related to r.75(2) of O.Reg 79/10.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Nutrition Manager, the Manager of Support Services, the Manager of Pharmacy and Quality, the Registered Dietitian (RD), Cooks, a Dietary Aide (DA), a Registered Nurse (RN), Registered Practical Nurses (RPNs), and Personal Support Worker's (PSWs).

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, and reviewed the home's supporting documentation, including relevant health care records, food production documents, applicable certification and training records, and specific licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Food Quality

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 71. (1)	CO #001	2019_740621_0006	621
O.Reg 79/10 s. 71. (1)	CO #002	2019_740621_0006	621
O.Reg 79/10 s. 75. (2)	CO #003	2019_740621_0006	621

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. 73. Dining and snack service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that food was served at a safe temperature to residents.

During observations completed for a specific number of meals over a specified number of days in October 2019, Inspector #621 observed the following:

a) During one specific meal in October 2019, Inspector #621 observed meal service commence at a certain time, with no temperatures recorded for any of the planned menu items. When temperatures were initiated by Cook #100 at a later specific time, the Inspector observed a particular menu option recorded at a specific temperature. When meal service was completed, the Inspector observed further temperatures taken by Cook #100 for a certain number of other menu items, with particular temperatures recorded.

Further, Inspector #621 observed at a specific time, a particular number of meals prepared and labelled to identify residents #002 and #003, which were left in a particular location within the meal assembly area. At a specified time later, Inspector #621 noted that both labelled meals were provided to nursing staff with no temperature measurement taken. When the Inspector inquired whether any temperatures had been taken of the plated meals for resident #002 and #003, prior to service, Cook #100 confirmed that no temperatures had been taken.

During a further interview with Cook #100, they reported to Inspector #621 that they had not had time to take any temperatures prior to service of that specific meal in October 2019. Cook #100 stated that all menu items were to have safe holding temperatures taken prior to service, with hot items kept at no less than 60 °C, and cold items kept at no greater than 4 °C. Cook #100 also confirmed that recorded temperatures for a specified number of menu items, were in an unsafe temperature range.

b) During another specific meal service, on another day in October 2019, Inspector #621 observed meal service commence at a specified time, with no recorded temperatures identified in the temperature log, prior to plating and serving a specific number of menu items, for a particular number of diet texture types.

During an interview with Cook #100, they reported to the Inspector that for the identified menu items, they had not taken temperatures prior to service. Additionally, Cook #100 confirmed that temperatures taken prior to meal service for other menu items, with specified diet textures, were within an unsafe temperature range.

Finally, Cook #100 confirmed that temperatures that were recorded to be within an unsafe temperature range before the start of meal service, had not been followed up immediately by themselves, or with assistance of their supervisor, in order to return the identified menu items to safe temperatures.

c) During a final meal service observation made the same day in October 2019, Inspector #621 observed meal service commence at a specified time. The Inspector observed PSW #110 take temperatures of a specific number of pre-plated meals.

During an interview with Cook #109 and PSW #110, the Inspector was informed that temperatures had been taken during production and at point-of-service, prior to meals being served to the residents. Cook #109 reported that they had been unable to locate the current days temperature log, so temperatures were recorded on previous days logs.

Inspector #621 reviewed temperatures recorded by Cook #109 during production, and identified a specific number and type of planned menu items, with unsafe temperatures.

On review of temperatures recorded by PSW #110 at point-of-service, the Inspector identified further unsafe temperature readings for a specific number of menu items, in both regular and texture modified states.

During further interviews with Cook #109 and PSW #110, they confirmed that safe hot holding temperatures were to be 60 °C or greater; and that temperatures recorded for the specified menu items and their diet texture types, were all found to be less than 60 °C, prior to service. Further Cook #109 confirmed that no attempt had been made to achieve safe temperature readings for the identified menu items prior to serving to the residents.

Inspector #621 reviewed the home's policy titled, "LTC - Dining and Snack Service, DIE-LTC-004", last updated January 21, 2019, which identified that hot meals were to be delivered promptly and maintain a temperature of no less than 60 °C; and cold foods were to be kept up to a maximum of 4 °C.

During an interview with the Nutrition Manager they reported to the Inspector that it was their expectation that safe hot holding temperatures were achieved and maintained throughout resident meal service; and temperatures were measured and recorded for all hot and cold menu items. [s.73. (1) 6.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the food production systems, at minimum, provided for the preparation of all menu items according to the planned menu.

During a dining observation made for a specific meal in October 2019, Inspector #621 observed only one of two planned dessert items served to residents.

During an interview with Cook #109, they reported that they had prepared menu items according to a specific week and day of the menu cycle, and had only prepared one of the two dessert items, according to the planned menu. Further, they reported to the Inspector that they had not prepared the alternate vegetable for that specific meal, but instead prepared a quantity of gravy, which had not been identified on the planned menu.

During an interview with the Director of Care, they reported to the Inspector that it was their expectation that food services staff prepared all menu items for resident meal service according to the planned menu. [s. 72. (2) (d)]

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 food is served at a safe temperature to residents, to be implemented voluntarily.

Issued on this 7th day of November, 2019

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIE KUORIKOSKI (621)
Inspection No. / No de l'inspection :	2019_740621_0033
Log No. / No de registre :	004004-19, 004005-19, 004006-19
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Nov 7, 2019
Licensee / Titulaire de permis :	Hornepayne Community Hospital 278 Front Street, P.O. Box 190, HORNEPAYNE, ON, P0M-1Z0
LTC Home / Foyer de SLD :	Hornepayne Community Hospital 278 Front Street, P.O. Box 190, HORNEPAYNE, ON, P0M-1Z0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Alison Morrison

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 Hornepayne Community Hospital, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee must be compliant with s.73(1)6 of Ontario Regulation 79/10. Specifically, the licensee must:

a) Ensure that the home has a process for monitoring and recording temperatures of all planned menu items, including menu additions and substitutions, before resident meal service is initiated;

b) Ensure a process is implemented, with supporting documentation, to immediately address any unsafe temperatures;

c) Ensure that there is training/re-training of all food services staff on safe hot and cold holding temperatures of menu items served to residents. Ensure that records are kept to identify who was trained, when the training occurred, and what the training entailed; and

d) Ensure that an auditing process is implemented at regular intervals, to monitor temperature records for accuracy, completeness, and to ensure unsafe temperatures have been actioned.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that food was served at a safe temperature to residents.

During observations completed for a specific number of meals over a specified number of days in October 2019, Inspector #621 observed the following:

a) During one specific meal in October 2019, Inspector #621 observed meal service commence at a certain time, with no temperatures recorded for any of the planned menu items. When temperatures were initiated by Cook #100 at a later specific time, the Inspector observed a particular menu option recorded at a specific temperature. When meal service was completed, the Inspector observed further temperatures taken by Cook #100 for a certain number of other menu items, with particular temperatures recorded.

Further, Inspector #621 observed at a specific time, a particular number of meals prepared and labelled to identify residents #002 and #003, which were left in a particular location within the meal assembly area. At a specified time later,

Inspector #621 noted that both labelled meals were provided to nursing staff with no temperature measurement taken. When the Inspector inquired whether any temperatures had been taken of the plated meals for resident #002 and #003, prior to service, Cook #100 confirmed that, "no" temperatures had been taken.

During a further interview with Cook #100, they reported to Inspector #621 that they had not had time to take any temperatures prior to service of that specific meal in October 2019. Cook #100 stated that all menu items were to have safe holding temperatures taken prior to service, with hot items kept at no less than 60 °C, and cold items kept at no greater than 4 °C. Cook #100 also confirmed that recorded temperatures for a specified number of menu items, were in an unsafe temperature range.

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prior to meals being served to the residents. Cook #109 reported that they had been unable to locate the current days temperature log, so temperatures were recorded on previous days logs.

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During an interview with the Nutrition Manager they reported to the Inspector that it was their expectation that safe hot holding temperatures were achieved and maintained throughout resident meal service; and temperatures were measured and recorded for all hot and cold menu items. [s.73. (1) 6.]

The severity of this issue was determined to be a level two, as there was a potential for harm to residents of the home. The scope of the issue was a level three, as the home failed to monitor and record food temperatures prior to resident meal service for all three dining observations. The home had a level two compliance history, as there was previous non-compliance with a different subsection of Ontario Regulation 79/10, within the previous 36 months. (621)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Feb 21, 2020

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 Health and 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:

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 Health and 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 de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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 de la Santé et 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 7th day of November, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julie Kuorikoski

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