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

North District
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Sudbury, ON, P3E 6A5
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Original Public Report

Report Issue Date: August 29, 2023	
Inspection Number: 2023-1262-0004	
Inspection Type: Proactive Compliance Inspection	
Licensee: Hornepayne Community Hospital	
Long Term Care Home and City: Hornepayne Community Hospital, Hornepayne	
Lead Inspector Karen Hill (704609)	**Inspector Digital Signature** Karen L Hill Digitally signed by Karen L Hill Date: 2023.09.07 13:56:09 -04'00'
Additional Inspector(s) Amanda Belanger (736)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: July 10-13, 2023.

- One Proactive Compliance Inspection (PCI) Intake was inspected.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Residents' and Family Councils
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care was revised when their care needs changed.

Rationale and Summary
A resident's plan of care identified that staff were to ensure specific interventions were implemented.

Upon observing the resident without the specific interventions implemented, a staff member identified that new interventions were being trialed with the resident; therefore, the other interventions were no longer needed by the resident. The staff member indicated that they would update the resident's plan of care to reflect the changes.

The resident's plan of care was revised prior to the completion of the inspection.

There was low risk of harm to the resident as staff who provided direct care to the resident were aware of the resident's care needs.

Sources: Observations; a resident's care plan; and interviews with staff members.

[736]

Date Remedy Implemented: July 13, 2023

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance of Abuse

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

The licensee has failed to ensure that the policy to promote zero tolerance of abuse was complied with.

Rationale and Summary
A staff member indicated they observed a situation that might have been staff to resident abuse but did not bring forward the concern right away.

The home's policy titled, "Abuse of Client-Prevention, Reporting and Elimination", indicated that staff were to bring forward concerns immediately.

The Administrator/Director of Care (DOC) confirmed that they had been made aware of an allegation of staff to resident abuse, a few days after it had taken place, and therefore the home's policy had not been complied with.

There was moderate risk to the residents in the home when the home's policy was not complied with, as the staff member who was involved in the situation of alleged abuse, continued to interact with all residents without the allegation being brought forward or investigated.

Sources: The home's policy titled, "Abuse of Client-Prevention, Reporting, and Elimination"; and interviews with the Administrator/DOC and other staff members.

[736]

WRITTEN NOTIFICATION: Quality - Action

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (3)

The licensee has failed to ensure that every reasonable effort to act on the results of the resident and family/caregiver experience survey and to improve the long-term care home (LTCH) and the care, services, programs and goods accordingly, was made.

Summary and Rationale
A copy of the most recent resident and family/caregiver satisfaction survey results was provided by the home. A record of any actions taken to improve the home based on the results of the survey could not be located.

The Administrator/DOC verified that no actions had been taken to make improvements, based on the results of the survey.

When the home did not act on the results of the satisfaction survey, there was potential risk to residents that the areas identified for improvement in the LTCH, may not have been addressed.

Sources: Observations; review of the home's resident/family satisfaction survey; and interviews with the Administrator/DOC and other staff members.

[704609]

WRITTEN NOTIFICATION: Residents' Council

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 62 (1)

The licensee has failed to ensure that a Residents' Council was established within the home.

Rationale and Summary
The home provided the minutes of the most recent Residents' Council meeting. No additional documentation was provided to indicate that Residents' Council meetings had been scheduled, or that a Residents' Council was in place.

The Administrator/DOC confirmed that Residents' Council meetings had not been scheduled within the last four months, nor did the home have a Residents' Council in place.

There was potential risk to residents when the home failed to establish a Residents' Council, as the residents did not have a process in place to collectively bring forward concerns or recommendations to the home.

Sources: The minutes of a Residents' Council meeting; the home's Activities calendars; and interviews with the Administrator/DOC and other staff members.

[736]

WRITTEN NOTIFICATION: Family Council

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 65 (7) (b)

The licensee has failed to ensure that when there was no Family Council, the licensee convened semi-annual meetings to advise the residents' families and persons of importance to residents, of the right to establish a Family Council.

Rationale and Summary
The home was unable to provide documentation that semi-annual meetings had occurred to advise residents' families and persons of importance to residents, of the right to establish a Family Council.

The Administrator/Director of Care (DOC) indicated they were not aware of the requirement.

There was minimal impact to residents when the home did not convene semi-annual meetings for residents' families and persons of importance, related to the right to establish a Family Council.

Sources: Observations of bulletin board in the home: Family Council section; and an interview with the Administrator/DOC.

[704609]

WRITTEN NOTIFICATION: Required Information

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 85 (3) (d)

The licensee has failed to ensure that the explanation of the duty to make mandatory reports, under section (s.) 28 of the FLTCA, 2021, was posted in the home.

Rationale and Summary
During the initial tour of the home, the explanation of the duty to make mandatory reports under s. 28, of the FLTCA, 2021, could not be located.

The Administrator/DOC confirmed that the home's mandatory reporting policy had not been posted within the home.

There was low risk to the residents in the home when the policy was not posted.

Sources: Observations; the home's policy titled, "Mandatory Reporting"; and an interview with the Administrator/DOC.

[736]

WRITTEN NOTIFICATION: Doors In A Home

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure that doors leading to non-residential areas were kept closed and locked when not being supervised by staff.

Rationale and Summary
At multiple times during the inspection, the doors to several non-residential areas were found open and unattended.

The Administrator/DOC acknowledged that doors leading to non-residential areas were to be kept closed and locked when not supervised by staff.

There was potential risk of harm to residents when the home failed to ensure that doors leading to non-residential areas were kept closed and locked when unattended, as residents in the home could have gained access to possibly harmful items stored in those areas.

Sources: Observations; email communication from the home; and interviews with the Administrator/DOC and other staff members.

[736]

WRITTEN NOTIFICATION: Air Temperature

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (3)

The licensee has failed to ensure that the air temperatures in two resident rooms in different parts of the home, as well a resident common area on each floor of the home, was measured and documented,

once every morning, once every afternoon between 12 p.m. and 5 p.m., and once every evening or night.

Rationale and Summary
The licensee was issued an exemption for air conditioning in resident rooms, for a specified period. The exemption letter reminded the licensee of the requirement to monitor and document temperatures in all resident rooms that did not have air conditioning.

The licensee was unable to produce any records to indicate that the air temperature was being monitored and documented in the home, as required in the Act.

The Maintenance Lead stated that they were unaware of the need to monitor the temperature in a common resident area; and that the home had not had access to the records or alerts for temperature monitoring.

There was moderate risk to the residents in the home, when the air temperatures were not being monitored as required.

Sources: Observations; the licensee's policy titled, "Cooling and Air Temperatures", and the licensee's Air Conditioning Exception Letter; and interviews with the Maintenance Lead and other staff members.

[736]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.

The licensee has failed to ensure that the Falls Prevention and Management program was evaluated and updated at least annually, in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Rationale and Summary
The home’s Fall Prevention and Management program was not reviewed or revised in the last calendar year.

The Administrator/DOC confirmed that the program should have been reviewed and updated annually,

and was not.

There was minimal risk and minimal impact to the residents, when the home failed to ensure, that at least annually, the home's falls prevention and management program was evaluated and updated.

Sources: The home's "Fall Prevention and Management" program, the tracking tool for mandatory program review; and interviews with the Administrator/DOC and other staff members.

[704609]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.

The licensee has failed to ensure that, a written record was kept related to the annual evaluation of the home's Skin and Wound and Pain Management programs, that included the names of the persons who participated in the evaluation, a summary of the changes made, and the date that those changes were implemented.

Rationale and Summary
The home's Skin and Wound and Pain Management programs were last reviewed in 2022. Documentation provided by the home did not include the names of the persons who participated in the reviews, any changes that were made, or the dates that any changes were implemented.

The Administrator/DOC identified that the process to review the programs had changed; that they were unaware of when the review had last occurred, what was discussed, or what changes were made.

There was minimal risk to residents when the home failed to keep a written record related to the annual evaluation of the Skin and Wound and Pain Management programs, which included the information required by the Act.

Sources: The home's "Skin and Wound" and "Pain Management" programs, the home's mandatory program review tracking document; and interviews with the Administrator/DOC and other staff members.

[704609]

WRITTEN NOTIFICATION: Menu Planning

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)

The licensee has failed to ensure that the planned menu items were offered and available at each meal.

Rationale and Summary
Meal options provided to residents during a meal service were not consistent with the planned menu items posted. Additionally, staff members indicated that only one dessert option was offered.

A resident stated that they had received the same meal option two days prior; the posted menu for that day did not have the substituted food items listed on the menu. A staff member verified that the meal options offered on that day were not consistent with the posted menu.

A dietary staff member acknowledged the discrepancy between the posted menus and the options offered to residents. They indicated that menu substitutions should not have occurred for one of the meals; that when substitutions were required, the nutritional values were to be checked to ensure they were of equal value, and the posted menu updated to reflect the options that were offered. Additionally, the Registered Dietitian (RD) stated that they should have been informed of the changes to the planned menu, to ensure that the residents' nutritional needs were being met.

When the planned menu items were not made available to residents, there was a potential impact on their dining experience which could have led to lower food intakes resulting in nutritional risk.

Sources: Observations of the posted menu, and of residents during meal service; and interviews with residents, a dietary staff member, the RD, and other staff members.

[704609]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 3.

The licensee has failed to ensure that the dining and snack service included monitoring of all residents

during meals.

Rationale and Summary
At the time of the inspection, residents were observed consuming food and fluids unattended.

A staff member verified that residents were not always monitored during their meals.

Failing to ensure all residents in the home were monitored during meal service, placed the residents at risk of not receiving the feeding assistance and interventions that they may have required during meals.

Sources: Observations of meal service, and of residents; and interviews with residents, RD, and other staff members.

[704609]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (15) 1.

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) lead worked regularly 17.5 hours per week, in that position, on site, at the home with a licensed bed capacity of 69 beds or fewer.

Rationale and Summary
The home had a 12 bed capacity and required an IPAC lead that worked 17.5 hours per week.

The IPAC lead identified that their primary responsibilities were not the home's IPAC program, nor did they work the required 17.5 hours per week in the role of IPAC lead.

The Administrator/DOC acknowledged that the home did not meet the current requirements related to the IPAC lead in the home.

Failing to ensure that the home had an IPAC lead who worked in the role for the required hours per week, may have contributed to the home not meeting all of the required IPAC components as outlined in the IPAC Standards for LTCHs.

Sources: Review of the IPAC lead's schedule, the home's IPAC lead job posting and IPAC lead job description, and the IPAC Standard for Long-Term Care Homes, dated April 2022; and interviews with the IPAC lead and Administrator/DOC.

[704609]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to IPAC was implemented;

1) Specifically, related to surveillance of symptoms indicating the presence of infection in residents.

Rationale and Summary
The IPAC Standard for LTCHs, dated 2022, identified that homes were to ensure that symptom screening information was gathered and that the information was analyzed daily to detect trends for the purpose of reducing the incidence of infections and outbreaks.

At the time of the inspection, the home was unable to provide any records that demonstrated the implementation of daily surveillance of symptoms indicating the presence of infection in residents.

The IPAC lead stated that the home used to have a daily list of resident symptoms and temperatures, however that practice had been discontinued. The Administrator/DOC verified daily surveillance was not occurring; that they were not aware of the requirements to do this, therefore, a process was not in place to ensure it had occurred.

Failing to ensure that surveillance of daily signs and symptoms of infection in residents was implemented in the home, placed residents at risk of possibly having any symptoms go unidentified and of a possible delay in outbreak identification.

Sources: The home's quarterly summary of presence of infection in residents, and the IPAC Standard for LTCHs, dated April 2022; and interviews with the IPAC lead and Administrator/DOC.

[704609]

2) Specifically, related to hand hygiene (HH).

Rationale and Summary
The IPAC Standard for LTCHs, dated 2022, identified that the home's IPAC program was to include support for residents to perform HH prior to receiving meals.

During an observation of a meal service, residents were not supported with HH prior to receiving their meals.

A resident verified they did not receive assistance with HH prior to their meals. The IPAC lead stated that staff were expected to assist all residents with HH when they entered the dining room and prior to meals.

There was low risk to the residents who did not receive assistance with HH.

Sources: Observations of meal service, review of home's "Hand Hygiene" policy, and the IPAC Standard for LTCHs; and interviews with a resident, the IPAC lead, and other staff members.

[704609]

WRITTEN NOTIFICATION: Quarterly Evaluation of Medication Review

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 124 (5)

The licensee has failed to ensure that a written record was kept of the results of the quarterly medication evaluation and any changes that were made.

Rationale and Summary
A copy of the home's last quarterly review of medication incidents and adverse drug reactions was requested; instead, the home provided a document of a medication incident that had occurred during the last quarter. The document did not indicate that a review of the incident had occurred.

The Administrator/DOC indicated that the home had reviewed the medication incident at the Medical Advisory Committee (MAC), but the requested information was not provided by the home.

There was minimal risk to the residents, when the home did not keep a documented record of the review of medication incidents that had occurred and of any changes implemented.

Sources: Review of the home's Quarterly/Safety notes, and the licensee's policy titled, "Medication Incidents"; and an interview with the Administrator/DOC.

[736]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (1)

The licensee has failed to ensure that the home had established a continuous quality improvement (CQI) committee.

Rationale and Summary
The home was unable to provide any records to demonstrate that they had established a CQI committee.

The Administrator/DOC, stated that they were the lead for the quality program for the home, however had not yet established a CQI committee for the home.

There was minimal risk to the residents when the home did not implement a CQI committee.

Sources: Interviews with the Administrator/DOC and other staff members.

[704609]

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (1)

The licensee has failed to prepare a report on the CQI initiative for the home for each fiscal year no later than three months after the end of the fiscal year.

Rationale and Summary
The home was unable to provide a final written report on the 2022-2023 CQI initiative for the home.

The Administrator/DOC acknowledged that the home had not prepared a CQI initiative report for the 2022-2023 fiscal year as required.

There was minimal risk to residents when the home did not prepare the CQI initiative report.

Sources: Review of the home's LTC 2022 resident/family satisfaction survey; and an interview with the DOC/Administrator.

[704609]

WRITTEN NOTIFICATION: Additional Training - Direct Care Staff

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (2) 1.

The licensee has failed to ensure that all staff who provided direct care to residents received annual training in all areas required under subsection 82 (7) of the Act.

Rationale and Summary
O. Reg. 246/22, s. 261 (1) identified that falls prevention and management, skin and wound care, and pain management, were areas in which licensees were required to ensure training for all staff who provided direct care to residents.

The home's educational records revealed that not all direct care providers had completed annual training in the areas required.

The Administrator/DOC confirmed that annual training was required however, was not always completed by the direct care staff.

Failing to ensure that all direct care staff completing annual training as required, placed residents at risk of not receiving the most current and relevant approaches to falls prevention and management, pain management, and skin and wound care.

Sources: Review Surge learning course completion records, the home's "Falls Prevention and Management", "Skin and Wound Care", and "Pain Management" programs; and interviews with the Administrator/DOC and other staff members.

[704609]

WRITTEN NOTIFICATION: Posting of Information

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.

The licensee has failed to ensure that the home's visitor policy was posted in the home.

Rationale and Summary
A binder of policy postings was observed during the initial tour of the home. It did not include a visitor policy.

The Administrator/DOC indicated that the visitor policy had not been updated since 2021 and that it was not posted in the home.

There was minimal risk of harm to the residents when the visitor policy was not posted in the home.

Sources: Observations; review of the home's policies; and an interview with the Administrator/DOC.

[736]

COMPLIANCE ORDER CO #001 Training - Orientation

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 82 (2)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:
1) Complete a documented review of the current Education Lead's roles and responsibilities to assess feasibility and ensure that the lead has the appropriate amount of time and resources to fulfill the role;
2) Develop a job description for the educational lead within the home;
3) Conduct a documented review of the educational modules available to staff upon hire; and determine

which modules need to be assigned to which classifications of staff upon hire, and annually thereafter;
4) Keep a record of which educational modules are to be completed by which classification upon hire, and annually thereafter for reference purposes;
5) Develop and implement a process for new staff to complete the required training modules, prior to starting their duties in the home;
6) Conduct a documented review of all staff who currently work within the LTCH, to determine which staff have not completed orientation modules, and which staff have not completed annual retraining; ensuring that the required training is completed as required.

Grounds
1) The licensee has failed to ensure that prior to performing their duties, staff received training related to the Residents' Bill of Rights; the LTCH's policy to promote zero tolerance of abuse and neglect of residents; the duty to make reports under s. 28; and the protections afforded in section 30, of the FLTCA, 2021.

Rationale and Summary
The educational records and staff lists provided by the home were reviewed during the course of the inspection.

Several staff members had not completed the orientation training required by the Act, prior to performing their duties.

The Administrator/DOC confirmed that the staff members had started working on the floor and were interacting with residents without the necessary training outlined in the Act.

There was moderate risk to the residents when staff did not receive the required training prior to performing their duties in their roles.

Sources: Review of the home's Surge Learning education records, and staff files; and interviews with the Administrator/DOC and other staff members.

[736]

2) The licensee has failed to ensure that various staff members completed their IPAC training prior to performing their responsibilities.

Rationale and Summary
Randomly selected IPAC training records reviewed for three staff hired after a specified date, revealed

that the staff members had not completed their IPAC training until several weeks after performing their duties. The training required under s. 82 of the FLTCA, 2021, was required within one week of hire. Further to this, the staff did not complete training in all eight required IPAC topics as identified in O. Reg. 246/22., s. 259 (2).

One of the staff members verified that they started their position prior to receiving IPAC training; and did not recall having received training on all eight required IPAC topics. The IPAC lead and Administrator/DOC verified that all staff were to complete IPAC training as required and on orientation as assigned.

Failing to ensure that newly hired staff completed IPAC training as required, increased the risk to residents of improper IPAC practices occurring within the home.

Sources: Observations of the home's IPAC practices; review of home's Surge Learning Education training records; and interviews with the IPAC lead, Administrator/DOC, and other staff members.

[704609]

This order must be complied with by December 28, 2023

COMPLIANCE ORDER CO #002 Implementation of Heat Related Illness Prevention and Management Plan

NC #021 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 23 (4)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure that they are compliant with s. 23 (4) of O. Reg. 246/22.

Specially the licensee shall:
1) Conduct an interdisciplinary review of the Heat Related Illness (HRI) plan within the home, ensuring that the plan is revised based on current best practice that is available. The home shall keep a record of the interdisciplinary review, including who participated in the review, and what changes were made;
2) Train all direct care staff, including PSWs, RPNs, Registered Nurses (RN), and Managers, on the heat related illness plan in the home;
3) Train all registered staff on the HRI assessment to be completed, including the date by which the annual assessments are to be completed;

4) Designate a lead to monitor the HRI assessments for residents to ensure that the HRIs are completed, and that all residents' plans of care are updated to include the individual risk levels and interventions;
5) Designate a staff member to monitor the air temperatures in two resident rooms, one common area, and any resident room that is not serviced by air conditioning. Address any deficiencies noted related to air temperatures not being monitored or documented and keep a written record of the actions taken to correct the deficiencies identified.

Grounds
The licensee has failed to ensure that a HRI prevention and management plan for the home was implemented every year during the period from May 15 to September 15.

Rationale and Summary
The licensee's HRI policy stated that all residents were to have a heat risk assessment completed, and the identification of their risk level for HRI, as well as interventions, added to their plan of care. A review of all residents' clinical health records revealed that none of the information required related to HRI was included.

The Administrator/DOC stated that a review of the home's HRI prevention and management plan had not occurred for a couple of years; and that staff members had not completed their training on the HRI plan. Furthermore, that since the assessments and care planning had not been completed for residents in the home, the HRI plan had not been implemented.

There was moderate risk to all residents in the home, when the licensee failed to implement the HRI prevention and management plan as required, as the home had an air conditioning exemption in place at the time.

Sources: All residents assessments and plans of care, the licensee's policy titled, "Prevention and Management of Hot Weather Related Illness", and internal training and education records; and interviews with the Administrator/DOC and other staff members.

[736]

This order must be complied with by December 28, 2023

COMPLIANCE ORDER CO #003 Registered Dietitian

NC #022 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 80 (2)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) Complete a documented review of the clinical and nutritional care duties carried out by the home's Registered Dietitian (RD), to ensure that all of the required roles and responsibilities of the RD are completed in the required timelines.
2) Develop and implement a process for tracking the dates and times the RD is onsite at the home.

Grounds
The licensee has failed to ensure that a RD who was a member of the staff of the home, was on site at the home for a minimum of 30 minutes per resident per month, to carry out the clinical and nutritional care duties.

Rationale and Summary
A review of a resident's clinical health record indicated that a nutritional assessment had not been completed by the RD. The home was unable to provide documentation that the RD had been onsite to complete the resident's admission nutritional assessment.

The RD identified that they usually tried to complete the nutritional risk assessments for new admissions, within 14 days; however in this case had not done so.

The Administrator/DOC confirmed that the RD had been working remotely and had not been onsite, at the home, for almost a year.

Failing to ensure that the RD was on site to carry out their clinical and nutritional care duties, placed the resident and other residents in the home at risk of not receiving the assessments and monitoring required, related to their nutritional care needs.

Sources: Observations of a resident; review of a residents clinical health record; and interviews with the RD, the Administrator/DOC, and other staff members.

[704609]

This order must be complied with by December 28, 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.