Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 29, 2020	2020_715672_0007	010416-20, 010420-20	Critical Incident System

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Altamont Care Community
92 Island Road SCARBOROUGH ON M1C 2P5

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

JENNIFER BATTEN (672)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 21, 22, 25-30, June 1-6, 8-13, 15-20 and 22-30, 2020

The following intakes were inspected during this Critical Incident System inspection:

One intake related to an alleged incident of improper/incompetent treatment of a resident.

One intake related to an alleged incident of staff to resident neglect.

During the course of the inspection, the inspector(s) toured the home, reviewed health care records, observed residents and staff to resident interactions, reviewed employee training records, schedules and internal policies related to Emergency Codes, Prevention of Abuse and Neglect, Pain Management, Skin and Wound Care, Infusion Therapy, Internal Transfers and Nutrition Care and Hydration.

PLEASE NOTE: Written Notifications, Voluntary Plans of Compliance and Compliance Orders related to LTCHA, 2007, r. 50. (2) (b) (iv) and r. 50. (2) (d), identified in this inspection have been issued in Inspection Report #2020_595110_0009, dated July 29, 2020, and a Voluntary Plan of Compliance related to LTCHA, 2007, r. 8. (1) (b), identified in this inspection have been issued in Inspection Report #2020_715672_0006, which were both conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Corporate Clinical Consultant, Director of Care (DOC), Associate Director of Care (ADOC), Acting Director of Care (DOC), Acting Associate Director of Care (ADOC), Resident Relations Coordinators, Nurse Practitioner (NP), RAI Coordinator, Skin and Wound Care Champion (SWCC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Services Manager (DSM) and dietary aides (DA), Registered Dietician (RD), Physiotherapists (PT) and physiotherapy assistants (PTAs), Director of Programs (DP) and recreational aides (RA), Office Manager (OM), Nursing/Scheduling Clerks, Environmental Support Manager (ESM) and environmental/housekeeping support staff (ESS/HSS), Physicians (MD), receptionists, Military clinical staff, Military support staff, Public Health Inspectors, Managers from the Centenary Health Services Hospital, family members, and residents.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
0 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were free from neglect by the staff in the home.

For the purposes of the Act and Regulation, “Neglect” is defined as:

“the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.” O. Reg. 79/10.

A Critical Incident Report was submitted to the Director related to an alleged incident of staff to resident neglect of resident #009. The CIR indicated that on an identified date, resident #009 transferred bedrooms. The CIR indicated this information was not passed along in shift report. The following day, the PSWs on duty were unaware of the resident’s whereabouts, as the nameplates on the outside of the resident bedrooms had not been transferred and the door to resident #009’s current bedroom had been left closed, therefore the staff were unaware the resident resided within, as that bedroom had been empty for the previous three or four days. The PSW and RPN #167 began searching for the resident and located the resident approximately half an hour later. This led to resident #009 not receiving care or repositioning for an identified period of time and very late medications and meal.

During an interview, PSW #101 indicated that on the identified shift, the unit resident #009 resided on was staffed by two staff members. There was also no Registered staff member assigned for the unit that shift, therefore the unit was being assisted by RPN #145, who was assigned to another unit, along with RPN #167, after they arrived for duty. PSW #101 indicated they had noticed that resident #009 was not in the bedroom they expected earlier that shift and had reported their finding to the RPN who was assisting in

covering the unit, but the RPN indicated they were also unaware of the resident's whereabouts and no actions were taken at that time. When RPN #167 began searching for resident #009 to administer medications, a room to room search was initiated and the resident was located. PSW #101 further indicated that when resident #009 had been transferred to the new bedroom the day prior, it had not been mentioned in the shift report and the name plates outside of the bedrooms had not been changed, therefore they still indicated resident #009 resided within the initial bedroom and the name plates outside of the bedroom resident #009 was moved into still listed the names of the previous residents, although those residents had previously passed away. PSW #101 indicated the bedroom door to resident #009's bedroom had been closed tightly when they came on shift, which was not a usual practice in the home when residents still resided in the rooms, therefore no one had been aware that resident #009 had been moved to the new bedroom. When resident #009 was located, PSW #101 indicated the resident required an entire bed bath and changing of all bed linens, due to the resident being incontinent. PSW #101 further indicated that resident #009 had ingested several glasses of fluids once they were located, as they complained of significant thirst due to missing breakfast and morning nourishment. After PSW #101 assisted in cleaning resident #009, changing the bed and assisting the RPN #167 with resident #009's skin care, they provided the resident with something to eat. PSW #101 indicated that resident #009 had not received any assistance with personal care, toileting or repositioning, food or fluids for an identified period of time.

During an interview, RPN #167 indicated that on the identified shift, they began assisting on resident #009's unit once they became aware the unit was short staffed and RPN #145 was assisting in covering two units. In an attempt to assist the RPN, they began administering some of the resident medications, as the RPN was a new staff member, was unfamiliar with the residents and had not started the morning medication pass on resident #009's unit. At an identified time, they became aware that resident #009 was not in their usual bedroom. When they could not ascertain where the resident was, they asked the RPN covering the unit if they were aware of resident #009's whereabouts. The RPN informed RPN #167 that PSW #101 had previously reported they were unaware of the resident's location, and knew that the resident could not self ambulate, therefore were not worried the resident had wandered away and hadn't had a chance to search for the resident due to being focused on completing the medication pass. RPN #167 then approached the PSWs on duty on resident #009's unit and was informed they were unaware of the resident's whereabouts, therefore a room to room search was initiated. Resident #009 was eventually located despite the bedroom door being tightly closed. The name plates outside the bedroom also still listed the names of the previous

occupants of the room and resident #009's name plate was still outside of their previous bedroom. Staff also had observed that some of resident #009's belongings remained in the previous bedroom. When resident #009 was located, they were noted to be exhibiting signs of pain; was soiled, as the resident had been incontinent several times; and a foul odour was noted in the bedroom related to resident #009's wound dressing, as it was noted to be heavily soiled with purulent drainage. RPN #167 indicated resident #009 complained of thirst and took three full glasses of fluids immediately once offered. Lastly, RPN #167 indicated resident #009 sustained several negative outcomes as a result of the incident.

During an interview, the Skin and Wound Care Champion (SWCC) indicated that resident #009 was at high risk for skin breakdown and had several identified skin and wound concerns. SWCC further indicated resident #009 required repositioning every one to two hours. SWCC indicated that if resident #009 was not repositioned according to the guidelines and/or the resident's plan of care, the resident may experience a worsening of their current identified skin concerns and/or develop new identified skin concerns.

Inspector #672 reviewed resident #009's health record for an identified period of time, and observed that resident #009's identified skin concern was noted to have worsened and was infected and required specific treatment.

During further record review, Inspector #672 reviewed the internal resident transfer policy, which indicated that for every resident move in/out or internal transfer, an identified form was to be utilized.

During separate interviews, Resident Relations Coordinator, ADOC #137 and IPAC lead #151, who were involved in resident #009's internal transfer, indicated the internal form was not utilized during resident #009's transfer. Resident Relations Coordinator and ADOC #137 further indicated they were unsure of how the information related to resident #009's internal transfer had been communicated to the oncoming shifts. IPAC lead #151 indicated they had informed the Registered staff on duty during the shift resident #009 was transferred that the resident had moved rooms, therefore assumed the information had been passed along in shift report to the oncoming shifts.

During separate interviews, the Acting DOC, Acting ADOC and the Corporate Clinical Consultant indicated the expectation in the home was for all residents to be assessed and repositioned, if required, at a minimum of every two hours, to ensure the residents were in a comfortable and safe position. They further indicated that the internal

investigation into the incident indicated that resident #009 had been neglected by staff on the identified shift, when the resident did not receive any care or support from staff until the resident was located in the new bedroom. This led to the resident not receiving medications or treatments as per physician's orders, not receiving breakfast or the morning nourishments on time and not receiving any continence or personal care, personal hygiene or repositioning for an identified period of time. The Acting DOC indicated that resident #009 sustained identified negative outcomes as a result of the incident of staff to resident neglect.

The licensee failed to ensure that resident #009 was free from neglect by staff on a specified date, when the resident's whereabouts were unknown for several hours, which led to the resident not receiving food/fluids or any personal or continence care or repositioning for an identified period of time. This led to the resident sustaining identified negative outcomes. [s. 19. (1)]

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. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's SDM was notified of the outcome of the neglect investigation immediately upon completion.

On an identified date, resident #009 was noted to have been neglected by the home for several hours and did not receive care.

Inspector #672 reviewed the internal investigation notes, resident #009's progress notes, and the internal risk management incident report but did not observe any documentation which indicated resident #009's Substitute Decision Maker (SDM) had been notified of the outcome of the internal investigation into the incident.

During an interview, the Corporate Clinical Consultant indicated they were unaware if resident #009's SDM had been notified of the outcome of the internal investigation into the incident, as the Acting DOC and Acting ADOC who had been responsible for the home at the time were in charge of the internal investigation. The Corporate Clinical Consultant further indicated the expectation in the home was for all residents/resident SDMs to be notified of all internal investigation outcomes related to allegations of resident abuse and/or neglect.

During an interview, the Acting DOC indicated they had forgotten to notify resident #009's SDM of the outcome of the internal investigation into the incident. The Acting DOC further indicated the expectation in the home was for all residents/resident SDMs to be notified of all internal investigation outcomes related to allegations of resident abuse and/or neglect.

The licensee failed to ensure that resident #009's SDM was notified of the outcome of the internal investigation into an allegation of staff to resident neglect. [s. 97. (2)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the report to the Director included the names of any staff members who were present at or discovered the incident, or who responded or were responding to the incident.

On an identified date, resident #009 was noted to have been neglected by the home for an identified period of time and did not receive care.

During record review, Inspector #672 reviewed the relevant records which indicated that resident #009 was transferred to a new bedroom due to specified reasons.

During review of the critical incident report, Inspector #672 observed the report did not include the names of the staff members involved in assisting resident #009 with transferring between bedrooms, the name of the PSW staff member who assisted resident #009 after they were located on the identified shift, or the name of the registered staff members who were on duty when resident #009 was transferred to the new bedroom, to assess if they had documented and passed this information along to the oncoming shifts.

During an interview, Acting ADOC #134 indicated they had submitted the report to the Director regarding the incident with resident #009. The Acting ADOC #134 indicated they had forgotten to include the names of PSW #101 who assisted resident #009 immediately after the resident was located following the search, the names of the staff members who were responsible for resident #009's room transfer, and the names of the registered staff on duty at the time the room transfer occurred. Lastly, the Acting ADOC #134 indicated they were aware of the legislative requirement which directed that the critical incident report was expected to include the names of any staff members who were present at or discovered the incident, or who responded or were responding to the incident.

The licensee failed to ensure that the critical incident report included the name of PSW #101 who assisted resident #009 immediately after the resident was located, the names of the staff members who were responsible for resident #009's room transfer, and the names of the registered staff on duty at the time the room transfer occurred.
[s. 104. (1) 2.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's substitute decision-maker was promptly notified of a serious injury to the resident, in accordance with any instructions provided by the person or persons who are to be so notified.

A Critical Incident Report was submitted to the Director related to an alleged incident of improper/incompetent treatment of resident #023, which resulted in harm to the resident. The CIR indicated that staff reported to the management team of the home that on an identified date, RPN #167 found resident #023 in bed in a distressed state.

Inspector #672 reviewed the internal investigation notes, critical incident report, progress notes and internal risk management incident report, but could not locate any documentation which indicated resident #023's substitute decision maker (SDM) was notified of the incident or the outcome of the internal investigation into the incident.

During separate interviews, the Acting DOC, Acting ADOC and the Corporate Clinical Consultant indicated they could not recall notifying resident #023's SDM of the incident or the outcome of the internal investigation. The Acting DOC, Acting ADOC and the Corporate Clinical Consultant further indicated they were aware of the legislative requirements which directed that residents and/or SDMs were to be notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified.

The licensee failed to ensure that resident #023's SDM was notified of an incident which caused a negative outcome to the resident. [s. 107. (5)]

Issued on this 30th day of July, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JENNIFER BATTEN (672)
Inspection No. / No de l'inspection :	2020_715672_0007
Log No. / No de registre :	010416-20, 010420-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 29, 2020
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Altamont Care Community 92 Island Road, SCARBOROUGH, ON, M1C-2P5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jane Smith

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Vigour Limited Partnership on behalf of Vigour General Partner Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19 of the LTCHA.

Specifically, the licensee must:

1. Develop a process to ensure that the internal resident census is accurate and reflects the resident's current location in the home.

2. The process must ensure that all staff are aware of and utilize the internal transfer policy, procedures and documents.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were free from neglect by the staff in the home.

For the purposes of the Act and Regulation, "Neglect" is defined as:

"the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents." O. Reg. 79/10.

A Critical Incident Report was submitted to the Director related to an alleged incident of staff to resident neglect of resident #009. The CIR indicated that on an identified date, resident #009 transferred bedrooms. The CIR indicated this information was not passed along in shift report. The following day, the PSWs on duty were unaware of the resident's whereabouts, as the nameplates on the outside of the resident bedrooms had not been transferred and the door to

resident #009's current bedroom had been left closed, therefore the staff were unaware the resident resided within, as that bedroom had been empty for the previous three or four days. The PSW and RPN #167 began searching for the resident and located the resident approximately half an hour later. This led to resident #009 not receiving care or repositioning for an identified period of time and very late medications and meal.

During an interview, PSW #101 indicated that on the identified shift, the unit resident #009 resided on was staffed by two staff members. There was also no Registered staff member assigned for the unit that shift, therefore the unit was being assisted by RPN #145, who was assigned to another unit, along with RPN #167, after they arrived for duty. PSW #101 indicated they had noticed that resident #009 was not in the bedroom they expected earlier that shift and had reported their finding to the RPN who was assisting in covering the unit, but the RPN indicated they were also unaware of the resident's whereabouts and no actions were taken at that time. When RPN #167 began searching for resident #009 to administer medications, a room to room search was initiated and the resident was located. PSW #101 further indicated that when resident #009 had been transferred to the new bedroom the day prior, it had not been mentioned in the shift report and the name plates outside of the bedrooms had not been changed, therefore they still indicated resident #009 resided within the initial bedroom and the name plates outside of the bedroom resident #009 was moved into still listed the names of the previous residents, although those residents had previously passed away. PSW #101 indicated the bedroom door to resident #009's bedroom had been closed tightly when they came on shift, which was not a usual practice in the home when residents still resided in the rooms, therefore no one had been aware that resident #009 had been moved to the new bedroom. When resident #009 was located, PSW #101 indicated the resident required an entire bed bath and changing of all bed linens, due to the resident being incontinent. PSW #101 further indicated that resident #009 had ingested several glasses of fluids once they were located, as they complained of significant thirst due to missing breakfast and morning nourishment. After PSW #101 assisted in cleaning resident #009, changing the bed and assisting the RPN #167 with resident #009's skin care, they provided the resident with something to eat. PSW #101 indicated that resident #009 had not received any assistance with personal care, toileting or repositioning, food or fluids for an identified period of time.

During an interview, RPN #167 indicated that on the identified shift, they began assisting on resident #009's unit once they became aware the unit was short staffed and RPN #145 was assisting in covering two units. In an attempt to assist the RPN, they began administering some of the resident medications, as the RPN was a new staff member, was unfamiliar with the residents and had not started the morning medication pass on resident #009's unit. At an identified time, they became aware that resident #009 was not in their usual bedroom. When they could not ascertain where the resident was, they asked the RPN covering the unit if they were aware of resident #009's whereabouts. The RPN informed RPN #167 that PSW #101 had previously reported they were unaware of the resident's location, and knew that the resident could not self ambulate, therefore were not worried the resident had wandered away and hadn't had a chance to search for the resident due to being focused on completing the medication pass. RPN #167 then approached the PSWs on duty on resident #009's unit and was informed they were unaware of the resident's whereabouts, therefore a room to room search was initiated. Resident #009 was eventually located despite the bedroom door being tightly closed. The name plates outside the bedroom also still listed the names of the previous occupants of the room and resident #009's name plate was still outside of their previous bedroom. Staff also had observed that some of resident #009's belongings remained in the previous bedroom. When resident #009 was located, they were noted to be exhibiting signs of pain; was soiled, as the resident had been incontinent several times; and a foul odour was noted in the bedroom related to resident #009's wound dressing, as it was noted to be heavily soiled with purulent drainage. RPN #167 indicated resident #009 complained of thirst and took three full glasses of fluids immediately once offered. Lastly, RPN #167 indicated resident #009 sustained several negative outcomes as a result of the incident.

During an interview, the Skin and Wound Care Champion (SWCC) indicated that resident #009 was at high risk for skin breakdown and had several identified skin and wound concerns. SWCC further indicated resident #009 required repositioning every one to two hours. SWCC indicated that if resident #009 was not repositioned according to the guidelines and/or the resident's plan of care, the resident may experience a worsening of their current identified skin concerns and/or develop new identified skin concerns.

Inspector #672 reviewed resident #009's health record for an identified period of time, and observed that resident #009's identified skin concern was noted to have worsened and was infected and required specific treatment.

During further record review, Inspector #672 reviewed the internal resident transfer policy, which indicated that for every resident move in/out or internal transfer, an identified form was to be utilized.

During separate interviews, Resident Relations Coordinator, ADOC #137 and IPAC lead #151, who were involved in resident #009's internal transfer, indicated the internal form was not utilized during resident #009's transfer. Resident Relations Coordinator and ADOC #137 further indicated they were unsure of how the information related to resident #009's internal transfer had been communicated to the oncoming shifts. IPAC lead #151 indicated they had informed the Registered staff on duty during the shift resident #009 was transferred that the resident had moved rooms, therefore assumed the information had been passed along in shift report to the oncoming shifts.

During separate interviews, the Acting DOC, Acting ADOC and the Corporate Clinical Consultant indicated the expectation in the home was for all residents to be assessed and repositioned, if required, at a minimum of every two hours, to ensure the residents were in a comfortable and safe position. They further indicated that the internal investigation into the incident indicated that resident #009 had been neglected by staff on the identified shift, when the resident did not receive any care or support from staff until the resident was located in the new bedroom. This led to the resident not receiving medications or treatments as per physician's orders, not receiving breakfast or the morning nourishments on time and not receiving any continence or personal care, personal hygiene or repositioning for an identified period of time. The Acting DOC indicated that resident #009 sustained identified negative outcomes as a result of the incident of staff to resident neglect.

The licensee failed to ensure that resident #009 was free from neglect by staff on a specified date, when the resident's whereabouts were unknown for several hours, which led to the resident not receiving food/fluids or any personal or continence care or repositioning for an identified period of time. This led to the resident sustaining identified negative outcomes.

The severity of this non-compliance is determined to be actual harm as the resident suffered a worsening condition and did not receive care for several hours. The scope of this non-compliance was isolated to this one resident. The compliance history indicated that there had been previous related areas of noncompliance noted in the home related to s. 19. (1), which included a VPC issued in a Critical Incident Report Inspection #2019_616722_0018.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 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 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 Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 29th day of July, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Batten

Service Area Office /
Bureau régional de services : Central East Service Area Office