Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection 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

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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
Mar 26, 2019	2019_643111_0005	026252-18, 002635-19	Complaint

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Bay Ridges
900 Sandy Beach Road PICKERING ON L1W 1Z4

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 19 and 20, 2019

There was a complaint (Log #002635-19) and a critical incident (CIR) that were inspected concurrently during this inspection as they both related to suspected staff to resident neglect.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Assistant Director of Care (ADOC), previous DOC, Registered Nurses (RN), Registered Practical Nurse (RPN) and Personal Support Workers (PSW).

During the course of the inspection, the inspector reviewed: the health care record of a deceased resident, the licensee's investigation, staff records and staff schedules.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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 :

The licensee has failed to ensure that a resident was free from neglect by the licensee or

staff in the home.

Under O.Reg. 79/10, s.5, Neglect means 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.

Related to Log # 002635-19:

A complaint was received on a specified date by the family of resident #001, alleging neglect of care as the resident had a significant change in condition and was left in bed unresponsive for a specified period of time on a specified date, when the resident was transferred to hospital.

Related to Log # 02625218:

A critical incident report (CIR) was also submitted to the Director on a specified date reporting an improper/incompetent treatment of a resident that resulted in harm or risk to a resident. The CIR indicated eight days earlier, at a specified time, resident #001 was noted to unresponsive for a specified period of time, when the Substitute Decision Maker (SDM) was contacted and they requested the resident be sent to the hospital. The resident was transferred to hospital and diagnosed with a significant change in condition. The CIR was completed by the previous Executive Director (ED).

Review of the progress notes for resident #001 indicated on a specified date and time, RN #100 documented they went to administer medications to the resident and the resident was observed to be unresponsive. RN #100 documented the resident did not receive any medications, meals, remained unresponsive for the entire shift, vital signs were obtained and were stable. The following shift, RN #101 indicated the resident's medications were held, no meals and the resident had remained unresponsive for most of their shift. At a specified time, RN #101 notified the SDM and the physician, they both requested the resident be sent to the hospital and the resident was then transferred to hospital for assessment. The following day, RN #100 documented an update was received from the hospital that the resident was being admitted with a specified diagnosis. Later the same day, the physician documented that the resident presented with decreased level of responsiveness yesterday, a call was received by the nurse and directed the nurse to send the resident to the hospital for assessment and they received the report from the hospital, that the resident had a specified diagnosis. The physician

indicated they phoned the SDM (at the request of RN #100) and the SDM was asking if they were aware the resident had been admitted to hospital with a specified diagnosis and the physician confirmed awareness. Later the same day, the former ED indicated they spoke to the SDM regarding the resident's condition. Five days later, the former ED indicated they spoke to the resident's SDM a second time and the SDM requested a meeting with the ED, which was scheduled for the following day. There was no documented evidence of the meeting with the family. Approximately two weeks later, the resident remained in the hospital on palliative care, was discharged from the home and subsequently passed away a short time later.

Review of the written plan of care for resident #001 (prior to the incident) indicated the resident required one staff extensive assistance with Activities of Daily Living (ADL). The resident could sleep in for breakfast but staff to offer the resident a breakfast tray or an alternative when the resident awakens (usually at a specified time) and otherwise ate in the dining room.

A review of the licensee's investigation and interviews with staff indicated:
- On the day the incident occurred, RPN #102 was assigned to provide care to resident #001 for the first three and half hours of the shift and then handed over care to RN #100, who was then assigned to the resident for the remainder of the eight hour shift. RPN #102 indicated the resident was last observed awake an hour after the start of their shift and they gave the resident their medications. RN #100 indicated they first checked on the resident at the start of their shift to administer medication and the resident was unresponsive. The RN indicated they went to administer the resident's medications again, just before lunch and the resident remained unresponsive, so they took the residents vital signs and reported their concerns to the Nurse Practitioner (NP), who was on the unit at the time and the NP directed them to continue to monitor. The RN confirmed they did not document this discussion with the NP. The RN confirmed they did not check on the resident again for the remainder of their shift, they did not check with the PSWs to determine if the resident had received any care/meals that shift. RN #100 no longer works in the home. PSW #104 and PSW #103 (was orientating) were also both assigned to provide care to the resident on the same specified shift. PSW #103 indicated they did not observe the resident until approximately three hours after the start of their shift, when they were directed by PSW#104 to provide care to the resident, confirmed the resident was unresponsive at that time and reported this to PSW #104. PSW #104 confirmed they did not observe or provide any care to the resident for their entire shift. PSW #103 no longer works in the home.
-The following shift, RN #101 and PSW #107 were assigned to provide care to the

resident. RN #101 indicated they observed the resident when they attempted to give the resident their medications and the resident was unresponsive. The RN confirmed awareness that the resident remained unresponsive the entire shift. The RN indicated they called the SDM at approximately three hours into their shift and left a message and when the family called back, they requested the resident be sent to hospital. The RN indicated they also then contacted the physician at that time and the resident was then transferred to hospital. RN #101 no longer works in the home. PSW #107 indicated when they arrived for their shift, they observed the resident approximately a half hour after the start of their shift and noted the resident was unresponsive and provided care. The PSW indicated the resident remained unresponsive and informed RN #101, was concerned about the resident and checked on the resident hourly until the resident was sent to hospital. The PSW confirmed it was very unusual for the resident to be unresponsive.
-The NP indicated they were only informed by RN #100 that the resident was sleeping and had stable vital signs, so they directed the RN to continue to monitor. The physician order indicated the physician was not contacted until 12 hours after the resident was found unresponsive.

During an interview with the ADOC, the ADOC indicated the previous DOC and ED that were in place at the time of the incident, no longer worked in the home. The ADOC confirmed they were involved in the investigation. The ADOC indicated the previous DOC and ED were notified the day after the incident occurred, by RN #100, that the family of resident #001 had called the home, expressed concerns as to why the resident had been unresponsive all day, with no food or medications and the resident was not sent to the hospital. The ADOC indicated the management team (ADOC, previous DOC and previous ED) reviewed the progress notes and were concerned regarding possible neglect of care to resident #001. The ADOC confirmed the investigation was initiated two days later and was not reported to the Director until seven days later.

During an interview with the previous DOC (#110), DOC #110 indicated on the day after the incident occurred, the ADOC was reviewing the resident's progress notes, spoke to RN #100 and the RN informed the ADOC of the above concerns raised by the family. DOC #110 indicated, the ADOC then had a discussion with the ED the same day. DOC #110 indicated they were not involved in the investigation.

The licensee failed to ensure that resident #001 was protected from neglect by the staff, when staff failed to respond to resident #001's change of condition where by the resident remained unresponsive on a specified date, for approximately 12hours, when the family and physician was notified, the staff were directed to transfer the resident to hospital and

was diagnosed with a specified diagnosis.

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 LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

The licensee failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported was immediately investigated:(ii) Neglect of a resident by the licensee or staff.

Related to Log # 002635-19 and Log # 026252-18:

A complaint was received on a specified date by the family of resident #001, alleging neglect of care as the resident had a significant change in condition and was left in bed unresponsive for a specified period of time on a specified date, when the resident was transferred to hospital.

A critical incident report (CIR) was also submitted to the Director on a specified date reporting an improper/incompetent treatment of a resident that resulted in harm or risk to

a resident. The CIR indicated eight days earlier, at a specified time, resident #001 was noted to be sleeping and unresponsive. The resident did not eat, drink or have any medications during a specified period of time. The resident remained unresponsive until a specified time, when the Substitute Decision Maker (SDM) was contacted and they requested the resident be sent to the hospital. The resident was transferred to hospital and diagnosed with a significant change in condition. The CIR was completed by the previous Executive Director (ED).

Review of the progress notes for resident #001 indicated on a specified date and time, RN #100 documented they went to administer medications to the resident and the resident was observed to be unresponsive. RN #100 documented the resident did not receive any medications, meals, remained unresponsive for the entire shift, vital signs were obtained and were stable. The following shift, RN #101 indicated the resident's medications were held, no meals and the resident had remained unresponsive for most of their shift. At a specified time, RN #101 notified the SDM and the physician, they both requested the resident be sent to the hospital and the resident was then transferred to hospital for assessment. The following day, RN #100 documented an update was received from the hospital that the resident was being admitted with a specified diagnosis. Later the same day, the physician documented that the resident presented with decreased level of responsiveness yesterday, a call was received by the nurse and directed the nurse to send the resident to the hospital for assessment and they received the report from the hospital, that the resident had a specified diagnosis. The physician indicated they phoned the SDM (at the request of RN #100) and the SDM was asking if they were aware the resident had been admitted to hospital with a specified diagnosis and the physician confirmed awareness. Later the same day, the former ED indicated they spoke to the SDM regarding the resident's condition. Five days later, the former ED indicated they spoke to the resident's SDM a second time and the SDM requested a meeting with the ED, which was scheduled for the following day. There was no documented evidence of the meeting with the family. Approximately two weeks later, the resident remained in the hospital on palliative care, was discharged from the home and subsequently passed away a short time later.

During an interview with the ADOC, the ADOC indicated the previous DOC and ED that were in place at the time of the incident, no longer worked in the home. The ADOC confirmed they were involved in the investigation. The ADOC indicated the previous DOC and ED were notified the day after the incident occurred, by RN #100, that the family of resident #001 had called the home, expressed concerns as to why the resident had been unresponsive all day with no food or medications given and was not informed until 12

hours later. The ADOC indicated the following day, the management team (ADOC, previous DOC and previous ED) reviewed the progress notes and were concerned regarding possible neglect of care to resident #001. The ADOC indicated that after a discussion with corporate, an investigation was initiated two days later.

During an interview with the previous DOC (#110), DOC #110 indicated on a specified date, the ADOC was reviewing the resident's progress notes and then spoke to RN #100 (who was working) and the RN informed the ADOC of the above concerns raised by the family. DOC #110 indicated, the ADOC then had a discussion with the ED the same day. DOC #110 indicated they were not involved in the investigation.

A review of the licensee's investigation indicated, the investigation commenced two days after the allegation was received from the family of neglect of care. All of the staff that were assigned to resident #001 on the day the incident occurred, continued to work and provide care to residents, up to and including the day the investigation was initiated. The family had called again, seven days later to further discuss their concerns and requested to meet with the home but there was no documented evidence of the meeting. RN #100 indicated they notified the NP of the resident's change in condition but there was no documented evidence in the resident's health record to indicated RN #100 reported the resident's condition to the NP.

The licensee failed to ensure that when RN #100, the previous ED, previous DOC and the ADOC, had reasonable grounds to suspect neglect of resident #001, as alleged and reported by resident #001's SDM on a specified date, immediately investigated the suspicion, as the investigation was not initiated until two days later.

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 any alleged, suspected or witnessed incidents of staff to resident neglect, are immediately investigated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee has failed to ensure that person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: 1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.

Related to Log # 002635-19:

A complaint was received on a specified date by the family of resident #001, alleging neglect of care as the resident had a significant change in condition and was left in bed unresponsive for a specified period of time on a specified date, when the resident was transferred to hospital.

Related to Log # 02625218:

A critical incident report (CIR) was also submitted to the Director on a specified date reporting an improper/incompetent treatment of a resident that resulted in harm or risk to a resident. The CIR indicated eight days earlier, at a specified time, resident #001 was noted to unresponsive for a specified period of time, when the Substitute Decision Maker (SDM) was contacted and they requested the resident be sent to the hospital. The resident was transferred to hospital and diagnosed with a significant change in condition. The CIR was completed by the previous Executive Director (ED).

During an interview with the ADOC, the ADOC indicated the previous DOC (#110) and ED that were in place at the time of the incident, no longer worked in the home. The ADOC indicated the management (previous DOC and ED) became aware of concerns about the resident's care by RN #100 the day after the incident occurred, when the RN informed them that the family of the resident had called with concerns related to the resident's care. The ADOC indicated the following day, a review was completed of the residents health record and also discovered some concerns with care. The ADOC indicated a discussion was completed with corporate and assumed the ED had reported the allegation to the Director.

During an interview with the previous DOC (#110), the DOC #110 indicated they recalled the incident involving resident #001. DOC #110 indicated on a specified date (the day after the incident occurred), the ADOC was reviewing the resident's notes, spoke to RN #100 (who was working), and the RN informed the ADOC of the concerns raised by the family. DOC #110 indicated, the ADOC then had a discussion with the ED. DOC #110 indicated that after the ADOC and ED looked into the incident further, they decided to initiate an investigation. The previous DOC confirmed they did not immediately report the alleged incident of staff to resident improper/incompetent care to the Director.

The licensee failed to ensure that when the ADOC, previous DOC, or previous ED had reasonable grounds to suspect on a specified date, that improper/incompetent treatment of resident #001, by the licensee or staff, that resulted in harm or risk of harm, was immediately reported to the Director, as the information was not provided to the Director until seven days later.

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 when a person has reasonable grounds to suspect improper care or incompetent treatment of a resident or neglect of a resident, the Director is immediately informed, to be implemented voluntarily.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 5th day of April, 2019

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

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

Ministère de la Santé et des Soins de longue durée

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) :	LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2019_643111_0005
Log No. / No de registre :	026252-18, 002635-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 26, 2019
Licensee / Titulaire de permis :	AXR Operating (National) LP, by its general partners c/o Revera Long Term Care Inc., 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4
LTC Home / Foyer de SLD :	Bay Ridges 900 Sandy Beach Road, PICKERING, ON, L1W-1Z4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Vanda Cozier

To AXR Operating (National) LP, by its general partners, 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 :

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 shall comply with LTCHA, 2007, s.19(1).

Specifically,

1. Educate all staff on the definition of "neglect" as defined by O.Reg. 79/10, s.5 which means 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. The education shall include the critical incident of resident #001 and acknowledge the pattern of inaction related to the failure of not responding to changes in the health status of residents.

2. Re-train all Personal Support Workers (PSW) on their roles and responsibilities, to include assigned residents are checked at the beginning of their shift, at least every two hours during their shift, or more frequently, if the resident has a change in condition, and prior to the end of their shift, and report any significant changes to the charge nurse immediately.

3. Ensure that all PSW's are aware of their responsibilities towards residents, when orientating new PSW's.

4. Re-train all Registered Nursing staff on their roles and responsibilities, regarding residents who have a significant change in condition, including notifications (of physician and/or NP and SDM) and documentations practices.

5.This re-training is to be documented.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident was free from neglect by the licensee or staff in the home.

Under O.Reg. 79/10, s.5, Neglect means 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.

Related to Log # 002635-19:

A complaint was received on a specified date by the family of resident #001, alleging neglect of care as the resident had a significant change in condition and was left in bed unresponsive for a specified period of time on a specified date, when the resident was transferred to hospital.

Related to Log # 02625218:

A critical incident report (CIR) was also submitted to the Director on a specified date reporting an improper/incompetent treatment of a resident that resulted in harm or risk to a resident. The CIR indicated eight days earlier, at a specified time, resident #001 was noted to unresponsive for a specified period of time, when the Substitute Decision Maker (SDM) was contacted and they requested the resident be sent to the hospital. The resident was transferred to hospital and diagnosed with a significant change in condition. The CIR was completed by the previous Executive Director (ED).

Review of the progress notes for resident #001 indicated on a specified date and time, RN #100 documented they went to administer medications to the resident and the resident was observed to be unresponsive. RN #100 documented the resident did not receive any medications, meals, remained unresponsive for the entire shift, vital signs were obtained and were stable. The following shift, RN #101 indicated the resident's medications were held, no meals and the resident had remained unresponsive for most of their shift. At a specified time, RN #101 notified the SDM and the physician, they both requested the resident be sent to the hospital and the resident was then transferred to hospital for assessment. The following day, RN #100 documented an update was received from the

hospital that the resident was being admitted with a specified diagnosis. Later the same day, the physician documented that the resident presented with decreased level of responsiveness yesterday, a call was received by the nurse and directed the nurse to send the resident to the hospital for assessment and they received the report from the hospital, that the resident had a specified diagnosis. The physician indicated they phoned the SDM (at the request of RN #100) and the SDM was asking if they were aware the resident had been admitted to hospital with a specified diagnosis and the physician confirmed awareness. Later the same day, the former ED indicated they spoke to the SDM regarding the resident's condition. Five days later, the former ED indicated they spoke to the resident's SDM a second time and the SDM requested a meeting with the ED, which was scheduled for the following day. There was no documented evidence of the meeting with the family. Approximately two weeks later, the resident remained in the hospital on palliative care, was discharged from the home and subsequently passed away a short time later.

Review of the written plan of care for resident #001 (prior to the incident) indicated the resident required one staff extensive assistance with Activities of Daily Living (ADL). The resident could sleep in for breakfast but staff to offer the resident a breakfast tray or an alternative when the resident awakens (usually at a specified time) and otherwise ate in the dining room.

A review of the licensee's investigation and interviews with staff indicated:
- On the day the incident occurred, RPN #102 was assigned to provide care to resident #001 for the first three and half hours of the shift and then handed over care to RN #100, who was then assigned to the resident for the remainder of the eight hour shift. RPN #102 indicated the resident was last observed awake an hour after the start of their shift and they gave the resident their medications. RN #100 indicated they first checked on the resident at the start of their shift to administer medication and the resident was unresponsive. The RN indicated they went to administer the resident's medications again, just before lunch and the resident remained unresponsive, so they took the residents vital signs and reported their concerns to the Nurse Practitioner (NP), who was on the unit at the time and the NP directed them to continue to monitor. The RN confirmed they did not document this discussion with the NP. The RN confirmed they did not check on the resident again for the remainder of their shift, they did not check with the PSWs to determine if the resident had received any care/meals

that shift. RN #100 no longer works in the home. PSW #104 and PSW #103 (was orientating) were also both assigned to provide care to the resident on the same specified shift. PSW #103 indicated they did not observe the resident until approximately three hours after the start of their shift, when they were directed by PSW#104 to provide care to the resident, confirmed the resident was unresponsive at that time and reported this to PSW #104. PSW #104 confirmed they did not observe or provide any care to the resident for their entire shift. PSW #103 no longer works in the home.
-The following shift, RN #101 and PSW #107 were assigned to provide care to the resident. RN #101 indicated they observed the resident when they attempted to give the resident their medications and the resident was unresponsive. The RN confirmed awareness that the resident remained unresponsive the entire shift. The RN indicated they called the SDM at approximately three hours into their shift and left a message and when the family called back, they requested the resident be sent to hospital. The RN indicated they also then contacted the physician at that time and the resident was then transferred to hospital. RN #101 no longer works in the home. PSW #107 indicated when they arrived for their shift, they observed the resident approximately a half hour after the start of their shift and noted the resident was unresponsive and provided care. The PSW indicated the resident remained unresponsive and informed RN #101, was concerned about the resident and checked on the resident hourly until the resident was sent to hospital. The PSW confirmed it was very unusual for the resident to be unresponsive.
-The NP indicated they were only informed by RN #100 that the resident was sleeping and had stable vital signs, so they directed the RN to continue to monitor. The physician order indicated the physician was not contacted until 12 hours after the resident was found unresponsive.

During an interview with the ADOC, the ADOC indicated the previous DOC and ED that were in place at the time of the incident, no longer worked in the home. The ADOC confirmed they were involved in the investigation. The ADOC indicated the previous DOC and ED were notified the day after the incident occurred, by RN #100, that the family of resident #001 had called the home, expressed concerns as to why the resident had been unresponsive all day, with no food or medications and the resident was not sent to the hospital. The ADOC indicated the management team (ADOC, previous DOC and previous ED) reviewed the progress notes and were concerned regarding possible neglect of

care to resident #001. The ADOC confirmed the investigation was initiated two days later and was not reported to the Director until seven days later.

During an interview with the previous DOC (#110), DOC #110 indicated on the day after the incident occurred, the ADOC was reviewing the resident's progress notes, spoke to RN #100 and the RN informed the ADOC of the above concerns raised by the family. DOC #110 indicated, the ADOC then had a discussion with the ED the same day. DOC #110 indicated they were not involved in the investigation.

The licensee failed to ensure that resident #001 was protected from neglect by the staff, when staff failed to respond to resident #001's change of condition where by the resident remained unresponsive on a specified date, for approximately 12hours, when the family and physician was notified, the staff were directed to transfer the resident to hospital and was diagnosed with a specified diagnosis.

The scope was a level one as only one resident was inspected. The severity was a level a level 3 as there was actual neglect to the resident and the resident sustained a stroke. The compliance history was a level 2 as the home had previous non-compliance that was is unrelated. (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 14, 2019

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 26th day of March, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

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