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 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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 30, 2016	2016_302600_0015	018634-16	Complaint

Licensee/Titulaire de permis

City of Toronto
55 JOHN STREET METRO HALL, 11th FLOOR TORONTO ON M5V 3C6

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

BENDALE ACRES
2920 LAWRENCE AVENUE EAST SCARBOROUGH ON M1P 2T8

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

GORDANA KRSTEVSKA (600)

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): September 19, 20, and 22, 2016.

During the course of the inspection the complaint log #018634-16 was inspected related Abuse and Neglect.

During the course of the inspection, the inspector(s) spoke with the director of nursing, nurse managers, registered nurse acting manager (RNANM) registered nurse in charge (RNIC), registered nurses (RNs), registered practical nurses (RPNs), personal care aides (PCAs), and substitute decision makers (SDMs).

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

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
0 VPC(s)
2 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	Legendé 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 the residents were not neglected by the licensee or staff.

Based on the severity of the outcome for the resident, and the home's history with respect to failing to ensure the residents were not neglected a compliance order is warranted.

Neglect, for the purposes of the Long-Term Care Homes Act and the Regulations O.Reg 79/10, s. 5., 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.

Review of the home’s policy #RC-0305-00 titled “Zero Tolerance of Abuse and Neglect" last revised on an identified date, states "the Long Term Care Homes and Services Division will not tolerate the neglect of any resident by any person. Neglect is defined as any action or inaction by any person against a resident that the person knew or ought to have known, would cause harm to the resident’s health, safety or well-being."

On an identified date, the Ministry of Health and Long Term Care (MOHLTC) Action Line received complaint regarding the death of resident #020. The complainant stated that the resident had not received proper care in the home upon his/her return from a hospital where resident was sent for further assessment.

Review of resident #020’s chart revealed the resident's needed extensive assistance to transfer and had used an assistive device for locomotion in and out of the home. The resident had been competent in making his/her own decision in all spheres and was therefore his/her own power of attorney (POA). The resident’s cognitive performance score indicated there was no cognitive impairment.

Review of resident #020’s progress notes, communication book and 24 hour nursing report over a 48 hour period of time revealed the following:
The resident had an unwitnessed incident in front of the home entrance when he/she was returning to the home. The resident lost his/her balance and the driver lowered the resident to the ground. Resident #020 was transferred to a hospital and the resident's family was notified. Review of the progress notes, 24 hour report and communication book failed to reveal if the RN assessed the resident after acknowledgement that resident had an incident, had been seen on the ground and had complained of discomfort.
The evening registered practical nurses (RPN) #122 and (RNIC) #119 had not contacted the hospital to follow up with the resident's condition.

The night RPN had not contacted the hospital for updates.
The next day RN #121 called the hospital and he/she had been notified that resident #020 sustained an injury and was in unstable condition. The hospital had planned to discharge the resident to the home after they stabilized the resident's condition.
Resident #020 returned to the home and RN #121 assessed the resident's vital signs indicating the condition was not stable. RN #121 had left a message to the family that resident had returned from the hospital.
RN #121 had communicated to the evening RPN #122 resident #020’s vital signs, and the resident's condition, reporting to the RPN the orders from the hospital and the interventions needed to be done.
RPN #122 contacted the family to obtain consent for a treatment ordered by the hospital but did not return a call to the family to provide an update of the resident's health condition. He/she had left a note in the communication book stating that the family is to be updated of resident's current condition.
Evening RPN #122 had observed the resident through the shift and noted resident #020 had a change in his/her health condition. Resident had not been able to eat, drink, or take his/her regular medication showing indication of having a discomfort. The RPN had not been able to complete resident's head-to-toe assessment because of the change in resident's condition.
RPN #122 communicated to RPN #123 that resident #020 had not been able to eat or drink and had a change in his/her health status.
On an identified date during the night shift RPN #123 observed resident to have changed health condition.
In the morning RPN #123 noted the resident's health condition to be worsening. Some nursing interventions had bee applied but resident #020's condition had not improved. RPN #123 had not been able to get a reading of the resident's vital signs. RPN #123 communicated to RN #121 the resident's health status during the night and had not been able to read resident's vital signs after several attempts.
That morning the attending PCA had reported to RPN #120 that resident #020's health condition worsened. RN #121 had been called and the resident was sent to the hospital. The RN had left a message to the family about resident’s transfer to the hospital.
At noon time RN #121 had called the hospital and the hospital confirmed the resident had deceased.

Interview with RNIC #119 revealed he/she had attended resident #020 after he/she received the call that the resident had an incident. He/she saw the resident and noted the resident had a change in the health condition. However RNIC #119 confirmed he/she had not assessed the resident #020, he/she went back on the floor as he/she assumed

the registered nurse acting manager (RNANM) #116 and director of care (DOC) #117 who happened to be there, would assess the resident.

Interview with RNANM #116 revealed he/she saw the resident on the ground and attended to make sure the resident received assistance. The RNANM confirmed the practise in the home when a resident has an incident, is for the registered staff member to assess the resident right there before the resident was moved. Further he/she confirmed RNIC #119 came down but had not assessed the resident. He/she went back on the floor to his/her regular duties before the resident was transferred to the hospital.

Interview with RNNM Falls Prevention lead #111 confirmed the practise in the home is for the resident to be assessed immediately after the registered staff is notified about an incident, and to complete a specified documentation later. Further RNNM #119 confirmed in this situation the RNIC should have assessed the resident when he/she saw the resident on the ground.

Interview with RNIC #119 also confirmed on an identified date, after resident #020 had been transferred to the hospital he/she had not contacted the hospital to follow up with the resident's condition. Further he/she confirmed because he/she had been busy, he/she assumed RPN #122 would call the hospital as the resident resided on his/her side of the floor.

Interview with RPN #122 confirmed he/she had not called the hospital to follow up about resident's condition because he/she had not communicated with the RNIC #119 as to who would call the hospital.

Interview with RN #121 revealed he/she was aware of resident #020's change in his/her health condition as he/she had contacted the hospital on a specified date, to follow up with the resident's health status, and he/she readmitted resident #020 on the same date, when the resident returned from the hospital. RN #121 assessed the resident and identified resident #020’s condition had changed as the resident had sustained injury and had change in his/her health condition. The RN confirmed he/she had not ensured and clarified what medication the resident had received while in the hospital. Further the RN confirmed he/she had not communicated to the physician the changes of resident #020's health condition.

Interview with RPN #122 revealed on an identified date, he/she had received shift report from RN #121 about resident #020 having a change in his/her health condition. Further

the RPN revealed he/she went to see the resident about an hour later to find him/her in a changed health condition. The RPN indicated resident #020 might have had discomfort because the resident expressed signs of discomfort. However, RPN # 122 confirmed he/she had not assessed the resident had not given any medication treatment to the resident #020. When asked why he/she had not given medication treatment, the RPN responded because the resident was not able to take any medication. He/she also confirmed he/she assumed the resident had received something for discomfort that morning in the hospital, while waiting to be transferred back to the home. Further the RPN confirmed he/she had not reported his/her finding to the RNIC and had not confirmed with the hospital what medication the resident had received in the hospital. RPN #122 also confirmed he/she had not communicated to the physician the changes of the resident #020's health condition and his/her concern that the resident was in discomfort and not able to take any medication. RPN #122 confirmed he/she had not called the resident's family back to update them with the current resident's condition as he/she had been busy.

Interview with RPN #123 confirmed on an identified date he/she had received a report from RPN #122 about resident #020 having changed health condition probably from medication taken while still at the hospital, and the resident had not taken anything by mouth. The RPN further confirmed he/she observed the resident through the night shift and found the resident to have changed health condition and had experienced discomfort. Further the RPN confirmed he/she had not communicated the resident's condition to the RN, or to the physician. The RPN confirmed he/she identified the resident was in discomfort but he/she took no action because the evening RPN had communicated that the resident might have had some medication in hospital. The RPN confirmed he/she had not called the hospital to clarify what medication the resident had received in the hospital. RPN #123 confirmed by the end of the shift the resident health condition significantly deteriorated.

Interview with RN #121 confirmed on an identified date during morning report RPN #123 had communicated to the RN #121 and RPN # 120 that the resident's health condition had been significantly deteriorated.

Interview with RN #121 and RPN #120 confirmed the registered staff had not checked the resident immediately after it was communicated to them there was a significant change in resident #020's health status. Half an hour later the attending PCA had found resident #020 unresponsive and called RN #121. The resident had been sent to the hospital. Further the RN confirmed when he/she called the hospital later on they notified

him/her the resident had deceased .

Interview with the complainant revealed on an identified date he/she had received a message from RN #121 the resident had returned to the home, but was not told any information about his/her health condition. The same day later afternoon he/she had received a call from RPN #122 to consent for doctor's order that medication needed to be paid for. The complainant responded to the RPN to talk to the resident as the resident was competent to make own decision. Then the RPN had told the complainant last time he/she had seen resident #020 four hours ago the resident was not able to respond to the RPN. The complainant stated it upset him/her as resident #020 had been always alert. It had concerned him/her as the resident had changed his/her health condition since earlier that morning when complainant had visited the resident in the hospital. The complainant also stated RPN #122 indicated he/she would check on the resident again and if something is wrong would call back. The complainant indicated since the RPN had not called back the resident must have recovered. Further the complainant indicated if the RPN had notified him/her that resident #020 had deteriorated and not able to make a decision, the complainant would decide to transfer the resident back to the hospital. The complainant also indicated that he/she could not understand why the registered staff had not taken any action when each of them had known the resident before and had identified resident #020's change in his/her health condition.

Interview with DOC confirmed there was a pattern of inaction in this case where all staff involved knew resident #020 had change in his/her health status and none of them completed a specified assessment. Further the DOC confirmed the staff had identified the resident had been in discomfort, yet none of them considered to use medication treatment. The DOC also confirmed during the home's investigation all interviewed staff noted resident #020 had change in his/her health condition, and they thought resident had received some "medication" in the hospital but none of them considered calling the hospital to ask what medication was given to the resident in the hospital or to notify the physician about resident #020's health condition. The DOC confirmed the practise in the home is set so that the resident who is coming back from a hospital is reassessed by the nurse on the floor, regardless if he/she is RPN or RN. If the RPN assessed the resident and he/she has a concern, he/she then calls the RN for further assessment; but if the RPN does not have a concern, the RN would not assess the resident regardless of the resident's change in health condition. The DOC acknowledged that this approach had not been helping in this residents' care. [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. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

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

On an identified date, the Ministry of Health and Long Term Care (MOHLTC) Action Line received complaint regarding the death of resident #020. The complainant stated that the resident had not received proper care in the home upon his/her return from a hospital where resident was sent for further assessment after a fall.

Review of resident #020's chart revealed the resident was admitted to the home on an identified date with multiple diagnosis. Resident #020 needed extensive assistance for transfer and had used an assisting device for locomotion in and out of the home. The resident had been competent in making his/her own decision in all spheres was therefore his/her own power of attorney (POA). The resident's cognitive performance score (CPS) was zero out of six which indicated there was no cognitive impairment.

Review of resident #020's progress notes, communication book and 24 hour nursing report from within an identified period of time , revealed resident #020 had an accident while transferring with his/her assisting device. Resident had been sent to the hospital and diagnosed. No invasive treatment had been performed and resident had been returned back to the home on the following day. On the day after resident's condition worsened and he/she was sent back in the hospital where resident #020 died after two

hours.

Review of the resident progress notes for two identified dates failed to reveal that resident #020 had been assessed when he/she returned from the hospital with change in his/her health condition. Further review revealed RN #121 had left a note in the communication book stating that the resident had to be assessed for discomfort and an identified change of the condition. Throughout the evening shift the progress notes revealed resident #020 had been having change in health condition and discomfort. The review of the evening progress notes failed to reveal that resident had been assessed for the discomfort during that evening. Review of the night shift progress notes revealed the resident's health condition had been deteriorating. The night shift progress notes failed to reveal that resident had been assessed for discomfort during the night of the identified date.

Review of resident #020's chart failed to reveal that the resident had been assessed for discomfort after he/she had returned from the hospital with a change in the health condition. Review of resident's medication administration record (MAR) failed to indicate that the resident had received medication during the shifts within the identified time period, prior to when he/she was sent back to the hospital and died two hours after.

Interview with RN #121 and RPNs #122 and #123 confirmed neither of them had assessed resident #020 for discomfort after he/she had returned from the hospital with changed health condition. Further, all registered staff involved confirmed the practice in the home was that the resident who had an incident must be assessed for discomfort and they all were aware of that practise.

Interview with DOC confirmed the practise in the home was that a resident who had a fall or return from a hospital must be assessed for discomfort. Further the DOC confirmed the staff had identified the resident had been in discomfort yet none of them assessed the resident for pain or consider to use an analgesic. [s. 52. (2)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 13th day of January, 2017

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

Original report signed by the inspector.

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) :	GORDANA KRSTEVSKA (600)
Inspection No. / No de l'inspection :	2016_302600_0015
Log No. / Registre no:	018634-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 30, 2016
Licensee / Titulaire de permis :	City of Toronto 55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6
LTC Home / Foyer de SLD :	BENDALE ACRES 2920 LAWRENCE AVENUE EAST, SCARBOROUGH, ON, M1P-2T8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Margaret Aerola

To City of Toronto, 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) (b)

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 prepare, submit and implement a plan for achieving compliance with LTCHA s. 19(1) to ensure that residents who experience a significant change in health status are not neglected by the licensee.

The plan must have the following elements in place:
- ensuring that an assessment appropriate to the condition to which the resident was hospitalized including but not limited to pain assessment including vital signs is conducted by the registered nursing staff.
- a process to ensure that information received from the hospital is implemented and/or communicated to all direct care staff to ensure continuity of care.
- a process to ensure that registered staff communicate findings to the physician.

- a process to ensure that communication to the SDM is established and maintained.
- a process to ensure written strategies are implemented that include monitoring, interventions and response to the intervention and communication to the nursing leadership about residents with significant change in health condition.

For all the above, as well as for any other elements included in the plan, please include who will be responsible for implementing, as well as a time line for achieving compliance, for each part of the plan.

Please submit the plan to Gordana.Krstevska@ontario.ca no later than December 30, 2016.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the residents were not neglected by

the licensee or staff.

Based on the severity of the outcome for the resident, and the home's history with respect to failing to ensure the residents were not neglected a compliance order is warranted.

Neglect, for the purposes of the Long-Term Care Homes Act and the Regulations O.Reg 79/10, s. 5., 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.

Review of the home's policy #RC-0305-00 titled “Zero Tolerance of Abuse and Neglect" last revised on an identified date, states "the Long Term Care Homes and Services Division will not tolerate the neglect of any resident by any person. Neglect is defined as any action or inaction by any person against a resident that the person knew or ought to have known, would cause harm to the resident's health, safety or well-being."

On an identified date, the Ministry of Health and Long Term Care (MOHLTC) Action Line received complaint regarding the death of resident #020. The complainant stated that the resident had not received proper care in the home upon his/her return from a hospital where resident was sent for further assessment.

Review of resident #020's chart revealed the resident's needed extensive assistance to transfer and had used an assistive device for locomotion in and out of the home. The resident had been competent in making his/her own decision in all spheres and was therefore his/her own power of attorney (POA). The resident's cognitive performance score indicated there was no cognitive impairment.

Review of resident #020's progress notes, communication book and 24 hour nursing report over a 48 hour period of time revealed the following:
The resident had an unwitnessed incident in front of the home entrance when he/she was returning to the home. The resident lost his/her balance and the driver lowered the resident to the ground. Resident #020 was transferred to a hospital and the resident's family was notified. Review of the progress notes, 24 hour report and communication book failed to reveal if the RN assessed the

resident after acknowledgement that resident had an incident, had been seen on the ground and had complained of discomfort.
The evening registered practical nurses (RPN) #122 and (RNIC) #119 had not contacted the hospital to follow up with the resident's condition.
The night RPN had not contacted the hospital for updates.
The next day RN #121 called the hospital and he/she had been notified that resident #020 sustained an injury and was in unstable condition. The hospital had planned to discharge the resident to the home after they stabilized the resident's condition.
Resident #020 returned to the home and RN #121 assessed the resident's vital signs indicating the condition was not stable. RN #121 had left a message to the family that resident had returned from the hospital.
RN #121 had communicated to the evening RPN #122 resident #020's vital signs, and the resident's condition, reporting to the RPN the orders from the hospital and the interventions needed to be done.
RPN #122 contacted the family to obtain consent for a treatment ordered by the hospital but did not return a call to the family to provide an update of the resident's health condition. He/she had left a note in the communication book stating that the family is to be updated of resident's current condition.
Evening RPN #122 had observed the resident through the shift and noted resident #020 had a change in his/her health condition. Resident had not been able to eat, drink, or take his/her regular medication showing indication of having a discomfort. The RPN had not been able to complete resident's head-to-toe assessment because of the change in resident's condition.
RPN #122 communicated to RPN #123 that resident #020 had not been able to eat or drink and had a change in his/her health status.
On an identified date during the night shift RPN #123 observed resident to have changed health condition.
In the morning RPN #123 noted the resident's health condition to be worsening. Some nursing interventions had bee applied but resident #020's condition had not improved. RPN #123 had not been able to get a reading of the resident's vital signs. RPN #123 communicated to RN #121 the resident's health status during the night and had not been able to read resident's vital signs after several attempts.
That morning the attending PCA had reported to RPN #120 that resident #020's health condition worsened. RN #121 had been called and the resident was sent to the hospital. The RN had left a message to the family about resident's transfer to the hospital.
At noon time RN #121 had called the hospital and the hospital confirmed the

resident had deceased.

Interview with RNIC #119 revealed he/she had attended resident #020 after he/she received the call that the resident had an incident. He/she saw the resident and noted the resident had a change in the health condition. However RNIC #119 confirmed he/she had not assessed the resident #020, he/she went back on the floor as he/she assumed the registered nurse acting manager (RNANM) #116 and director of care (DOC) #117 who happened to be there, would assess the resident.

Interview with RNANM #116 revealed he/she saw the resident on the ground and attended to make sure the resident received assistance. The RNANM confirmed the practise in the home when a resident has an incident, is for the registered staff member to assess the resident right there before the resident was moved. Further he/she confirmed RNIC #119 came down but had not assessed the resident. He/she went back on the floor to his/her regular duties before the resident was transferred to the hospital.

Interview with RNNM Falls Prevention lead #111 confirmed the practise in the home is for the resident to be assessed immediately after the registered staff is notified about an incident, and to complete a specified documentation later. Further RNNM #119 confirmed in this situation the RNIC should have assessed the resident when he/she saw the resident on the ground.

Interview with RNIC #119 also confirmed on an identified date, after resident #020 had been transferred to the hospital he/she had not contacted the hospital to follow up with the resident's condition. Further he/she confirmed because he/she had been busy, he/she assumed RPN #122 would call the hospital as the resident resided on his/her side of the floor.

Interview with RPN #122 confirmed he/she had not called the hospital to follow up about resident's condition because he/she had not communicated with the RNIC #119 as to who would call the hospital.

Interview with RN #121 revealed he/she was aware of resident #020's change in his/her health condition as he/she had contacted the hospital on a specified date, to follow up with the resident's health status, and he/she readmitted resident #020 on the same date, when the resident returned from the hospital. RN #121 assessed the resident and identified resident #020’s condition had

changed as the resident had sustained injury and had change in his/her health condition. The RN confirmed he/she had not ensured and clarified what medication the resident had received while in the hospital. Further the RN confirmed he/she had not communicated to the physician the changes of resident #020's health condition.

Interview with RPN #122 revealed on an identified date, he/she had received shift report from RN #121 about resident #020 having a change in his/her health condition. Further the RPN revealed he/she went to see the resident about an hour later to find him/her in a changed health condition. The RPN indicated resident #020 might have had discomfort because the resident expressed signs of discomfort. However, RPN # 122 confirmed he/she had not assessed the resident had not given any medication treatment to the resident #020. When asked why he/she had not given medication treatment, the RPN responded because the resident was not able to take any medication. He/she also confirmed he/she assumed the resident had received something for discomfort that morning in the hospital, while waiting to be transferred back to the home. Further the RPN confirmed he/she had not reported his/her finding to the RNIC and had not confirmed with the hospital what medication the resident had received in the hospital. RPN #122 also confirmed he/she had not communicated to the physician the changes of the resident #020's health condition and his/her concern that the resident was in discomfort and not able to take any medication. RPN #122 confirmed he/she had not called the resident's family back to update them with the current resident's condition as he/she had been busy.

Interview with RPN #123 confirmed on an identified date he/she had received a report from RPN #122 about resident #020 having changed health condition probably from medication taken while still at the hospital, and the resident had not taken anything by mouth. The RPN further confirmed he/she observed the resident through the night shift and found the resident to have changed health condition and had experienced discomfort. Further the RPN confirmed he/she had not communicated the resident's condition to the RN, or to the physician. The RPN confirmed he/she identified the resident was in discomfort but he/she took no action because the evening RPN had communicated that the resident might have had some medication in hospital. The RPN confirmed he/she had not called the hospital to clarify what medication the resident had received in the hospital. RPN #123 confirmed by the end of the shift the resident health condition significantly deteriorated.

Interview with RN #121 confirmed on an identified date during morning report RPN #123 had communicated to the RN #121 and RPN # 120 that the resident's health condition had been significantly deteriorated.

Interview with RN #121 and RPN #120 confirmed the registered staff had not checked the resident immediately after it was communicated to them there was a significant change in resident #020's health status. Half an hour later the attending PCA had found resident #020 unresponsive and called RN #121. The resident had been sent to the hospital. Further the RN confirmed when he/she called the hospital later on they notified him/her the resident had deceased .

Interview with the complainant revealed on an identified date he/she had received a message from RN #121 the resident had returned to the home, but was not told any information about his/her health condition. The same day later afternoon he/she had received a call from RPN #122 to consent for doctor's order that medication needed to be paid for. The complainant responded to the RPN to talk to the resident as the resident was competent to make own decision. Then the RPN had told the complainant last time he/she had seen resident #020 four hours ago the resident was not able to respond to the RPN. The complainant stated it upset him/her as resident #020 had been always alert. It had concerned him/her as the resident had changed his/her health condition since earlier that morning when complainant had visited the resident in the hospital. The complainant also stated RPN #122 indicated he/she would check on the resident again and if something is wrong would call back. The complainant indicated since the RPN had not called back the resident must have recovered. Further the complainant indicated if the RPN had notified him/her that resident #020 had deteriorated and not able to make a decision, the complainant would decide to transfer the resident back to the hospital. The complainant also indicated that he/she could not understand why the registered staff had not taken any action when each of them had known the resident before and had identified resident #020's change in his/her health condition.

Interview with DOC confirmed there was a pattern of inaction in this case where all staff involved knew resident #020 had change in his/her health status and none of them completed a specified assessment. Further the DOC confirmed the staff had identified the resident had been in discomfort, yet none of them considered to use medication treatment. The DOC also confirmed during the home's investigation all interviewed staff noted resident #020 had change in

his/her health condition, and they thought resident had received some "medication" in the hospital but none of them considered calling the hospital to ask what medication was given to the resident in the hospital or to notify the physician about resident #020's health condition. The DOC confirmed the practise in the home is set so that the resident who is coming back from a hospital is reassessed by the nurse on the floor, regardless if he/she is RPN or RN. If the RPN assessed the resident and he/she has a concern, he/she then calls the RN for further assessment; but if the RPN does not have a concern, the RN would not assess the resident regardless of the resident's change in health condition. The DOC acknowledged that this approach had not been helping in this residents' care. [s. 19. (1)] (600)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 15, 2017

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Order / Ordre :

The licensee must ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose and receives effective pain management as per the home's policy.

Grounds / Motifs :

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

On an identified date, the Ministry of Health and Long Term Care (MOHLTC) Action Line received complaint regarding the death of resident #020. The complainant stated that the resident had not received proper care in the home upon his/her return from a hospital where resident was sent for further assessment after a fall.

Review of resident #020's chart revealed the resident was admitted to the home on an identified date with multiple diagnosis. Resident #020 needed extensive assistance for transfer and had used an assisting device for locomotion in and out of the home. The resident had been competent in making his/her own decision in all spheres was therefore his/her own power of attorney (POA). The resident's cognitive performance score (CPS) was zero out of six which indicated there was no cognitive impairment.

Review of resident #020's progress notes, communication book and 24 hour nursing report from within an identified period of time , revealed resident #020

had an accident while transferring with his/her assisting device. Resident had been sent to the hospital and diagnosed. No invasive treatment had been performed and resident had been returned back to the home on the following day. On the day after resident's condition worsened and he/she was sent back in the hospital where resident #020 died after two hours.

Review of the resident progress notes for two identified dates failed to reveal that resident #020 had been assessed when he/she returned from the hospital with change in his/her health condition. Further review revealed RN #121 had left a note in the communication book stating that the resident had to be assessed for discomfort and an identified change of the condition. Throughout the evening shift the progress notes revealed resident #020 had been having change in health condition and discomfort. The review of the evening progress notes failed to reveal that resident had been assessed for the discomfort during that evening. Review of the night shift progress notes revealed the resident's health condition had been deteriorating. The night shift progress notes failed to reveal that resident had been assessed for discomfort during the night of the identified date.

Review of resident #020's chart failed to reveal that the resident had been assessed for discomfort after he/she had returned from the hospital with a change in the health condition. Review of resident's medication administration record (MAR) failed to indicate that the resident had received medication during the shifts within the identified time period, prior to when he/she was sent back to the hospital and died two hours after.

Interview with RN #121 and RPNs #122 and #123 confirmed neither of them had assessed resident #020 for discomfort after he/she had returned from the hospital with changed health condition. Further, all registered staff involved confirmed the practice in the home was that the resident who had an incident must be assessed for discomfort and they all were aware of that practice.

Interview with DOC confirmed the practice in the home was that a resident who had a fall or return from a hospital must be assessed for discomfort. Further the DOC confirmed the staff had identified the resident had been in discomfort yet none of them assessed the resident for pain or consider to use an analgesic. [s. 52. (2)] (600)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 15, 2017

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 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 30th day of November, 2016

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Gordana Krstevska

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