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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 2, 2020	2020_769646_0007	007598-20, 007996-20, 008042-20, 009294-20	Complaint

Licensee/Titulaire de permis

Rykka Care Centres LP
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

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

Hawthorne Place Care Centre
2045 Finch Avenue West NORTH YORK ON M3N 1M9

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

IVY LAM (646)

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): Onsite: May 13, 2020; and May 14, 15, 19, 20, 21, and 25, 2020, as an off-site inspection.

**The following intakes were inspected during this inspection:
Logs #007598-20, 007996-20, 008042-20, and 009294-20 related to infection prevention and control, and hospitalization and change in condition.**

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), acting Director of Care (DOC), Assistant Directors of Care (ADOC), Quality Improvement Coordinator, Nursing Coordinator/Scheduler, Infection Prevention and Control (IPAC) lead-Clinical Practice Coordinator (CPC), Registered Nurses (RN), Registered Practical Nurses (RPNs), Agency RPNs, Personal Support Workers (PSWs), Substitute Decision Makers, and Family Members.

**The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition**

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

- **1 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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

**s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).**

**s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).**

Findings/Faits saillants :

1. The licensee has failed to ensure that staff monitored symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

This inspection was initiated related to a complaint received by the Ministry of Long-Term Care (MLTC) related to resident #004, who was sent to the hospital with an identified temperature an identified date, and passed away in the hospital.

Review of the COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7, with effective date of implementation on March 30, 2020, showed that Long-term care homes must immediately implement the following precautions and procedures:

- Active Screening of all Residents. Long-term care homes must conduct active screening of all residents, at least twice daily (at the beginning and end of the day) to identify if any resident has fever, cough or other symptoms of COVID-19.

Review of resident #004's temperature summary and progress notes on PointClickCare (PCC) for an identified 14-day period, showed that no temperature check was recorded for the resident on:
- Day and evening shifts on two identified dates,
- Day shift on one identified date, and
- Evening shifts on five identified dates.

Interview with the unit clerk showed that the home's usual staffing complement on the identified floor that resident #004 resided were: An identified number of Personal Support Workers (PSWs) and Registered Practical Nurses (RPNs) during the day shift, and another identified number of PSWs, but the same number of RPNs for the evening shift.

Review of the home's staffing list for the identified floor showed that the staffing level was less than the usual staffing complement on seven of the above mentioned dates for both PSWs and RPNs.

Interview with RPN #115, who worked on four shifts and had documented the administration of medication on the electronic Medication Administration Record (eMAR) for resident #004 but did not record any temperature on the four identified shifts for resident #004. They stated that it is their usual practice to take residents' temperature on day and evening shifts for all residents. However, during the identified week above, the RPN stated there were multiple shifts where they were the only RPN on the identified floor, with very few PSWs on the floor and the staff were very busy.

Interview with RPN #106 who worked on two identified shifts in the period above, stated the registered staff should check the resident's temperature twice daily, during morning and evening shift. The RPN stated that they were new to the home at this time, and they documented what they had done on PCC. The RPN could not recall whether they had taken the resident's temperature. However, no documentation of temperature check was done on the two identified shifts that they had worked.

Interview with Assistant Director of Care (ADOC) #114 in the home, who also worked as an RN on an identified shift to administer medications to residents, stated that it was the role of the registered staff who was assigned to administer residents' medication to also do temperature checks of residents on day and evening shifts. ADOC #114 stated that on that identified shift, they were the only ADOC available, as the other two ADOCs were not working, and they also had to administer medications due to the shortage of registered staff in the home. ADOC #114 could not recall why they did not take resident #004's temperature that day, but stated it was their responsibility to take the temperature for resident #004 that day during day shift.

In interview with the IPAC lead-Clinical Practice Coordinator (CPC), they stated that it is the home's expectation to have the registered staff do two temperature checks for the resident, once during day shift and once during evening shift, in accordance with the current directives for long-term care homes. However, the IPAC lead-CPC was ill and

away from the home starting on an identified date for three weeks.

Interview with the Executive Director (ED) stated that there were no complaints or concerns received regarding any issues with the availability of thermometers in the home in the identified month in question.

Interviews with the acting Director of Care (DOC) and ED stated that it was the home's expectation for staff to check and document the residents' temperatures on day and evening shifts for all residents as per current practice, and this was not done for resident #004 on the above-mentioned shifts. [s. 229. (5) (a)]

2. The licensee has failed to ensure that staff on every shift recorded symptoms of infection in residents and took immediate action as required.

This inspection was initiated related to multiple complaints received by the MLTC related to resident #008, who passed away in the home on an identified date.

Review of resident #008's temperature summary and progress notes on PointClickCare (PCC) for the identified month that resident passed away showed that the resident's temperature was taken twice daily for an identified period. Review of the temperature summary and progress notes showed that resident #008 had a temperature recording higher than 37.8 C twice during the period above: On the first identified date on an identified shift, RPN #103 recorded an identified elevated temperature for resident #008, and on a second identified date on an identified shift, RPN #106 recorded another identified elevated temperature for resident #008.

Review of resident #008's progress notes and eMAR on the first identified date, showed that RPN #103 provided the resident with an identified medication when necessary / pro re nata (PRN) and rechecked the temperature, encouraged fluids for the resident, and documented for the next shift to continue to monitor. Review of documentation for the next shift, showed that RPN #108 rechecked the resident's temperature twice, and the temperature was below 37.8 C. Resident #008's temperature on the shift afterward also showed a temperature below 37.8 C.

Review of resident #008's temperature summary on the second identified date showed the resident had a temperature above 37.8 C on an identified shift at an identified time. Review of the progress notes on the same day, documented at 30 minutes after the

identified recorded temperature, showed that a PSW had alerted RPN #106 that resident #008 appeared unwell. The PSW was not named in the progress notes and RPN #106 could not recall who the PSW was. RPN #106 had rechecked the resident’s temperature to be below 37.8 C at this point. However, RPN #106 documented that the resident’s oxygen saturation level was at an identified level that was lower than normal. The RPN documented that they left the resident in their bed, and for the next shift to continue to monitor the resident.

Review of resident #008’s temperature summary for next shift showed a temperature below 37.8 C, documented at the end of shift. No documentation regarding resident’s oxygen saturation level was identified for the identified shift, and no comment regarding the resident’s temperature was seen in the progress notes.

Review of the eMAR did not show any documentation that PRN medication was offered to the resident on the second identified date during the identified shift when the resident had a recorded temperature of higher than 37.8 C.

Interview with RPN #103 who worked with resident #008 on three identified shifts two days prior to resident #008’s passing stated the resident was their usual self, and continued to eat and drink as normal, and continued to communicate with the staff as normal.

Interview with RPN #106 stated they were new to the home and could not recall resident #008. Upon reviewing resident #008’s progress notes and temperature summary, the RPN stated they could not recall if they documented the correct oxygen saturation level, or if they had provided any treatment for the resident for the elevated temperature, or to address the oxygen saturation on the second identified date. RPN #106 further stated, if the resident had a fever, they would provide PRN medication and provide a cool cloth for the resident, and if the resident’s oxygen level was below 90%, they would have administered oxygen, and inform the nurse in charge and the doctor. RPN #106 further stated they would document in the progress notes the actions they took.

Interview with Agency RPN #101 who worked on an identified shift in the second identified date stated that they had only worked a few shifts in the home and could not recall resident #008. RPN #101 further stated that they were not informed by the previous shift during shift report for any particular resident to specifically monitor, and did not check any vitals, including the oxygen saturation, for the residents outside of the regular temperature check. The RPN further stated that there was no resident with

elevated temperature during the shifts that they had worked. The RPN also stated that no PSW had informed them that any resident was unwell when they had worked.

Interview with PSW #102 who had found the resident unresponsive on the identified shift that the resident had passed away stated that there were very few PSWs and registered staff working at the time, and the PSW did rounds to check on residents, and found that resident #008 was in bed. When PSW #102 returned to resident #008 for care, the PSW realized the resident was not responsive when they touched their hand and face and went to get RPN #104.

Interview with RPN #104 stated that prior to the start of shift, no one had informed the RPN of any concerns for resident #008 from previous shifts. The RPN further stated that at the time, the home was very short staffed, and the RPN had to help with two floors. They further stated that they had not read that the resident had a fever or low oxygen saturation from previous shifts. The RPN stated that PSW #102 had informed them that resident #008 was in their bed and unresponsive. The RPN stated when they had arrived to see resident #008, the resident was in bed with no vital signs. The RPN then called and informed the doctor to describe what they had seen, and the doctor determined an identified cause of death.

Interviews with the acting DOC and the ED stated that if a resident has a fever, it is the home’s expectation for staff to provide PRN medication to lower the resident's temperature as per the order, to inform the physician, and to communicate to staff on subsequent shifts and monitor the resident to treat the symptoms. The acting DOC and ED further stated that if a resident has low oxygen saturation, they would expect the staff to provide oxygen, notify the physician if the oxygen level does not improve, and monitor for visible signs of distress and difficulty breathing. They stated they were not certain if RPN #106 had documented the oxygen saturation level correctly on the second identified date, but action should have been taken on subsequent shifts related to the elevated temperature and documented oxygen level identified on the second identified date, and this was not done for resident #008. [s. 229. (5) (b)]

3. This inspection was initiated related to a complaint received by the MLTC related to the death of resident #004, who was sent to the hospital with an identified temperature above 37.8 C on an identified date and passed away in the hospital four days later.

Review of resident #004’s temperature summary showed that RPN #115 had

documented that resident #004 had a temperature above 37.8 C at the end of the shift, two shifts prior to the resident being sent to the hospital. No other documentation was found on the temperature summary for resident #004 on that identified shift.

Review of resident #004's eMAR on the identified shift showed that RPN #115 provided the resident their identified regular medication, but did not administer the resident's PRN medication on the identified shift when the resident had an identified temperature above 37.8 C.

Review of the progress notes did not show any documentation on the identified shift when the resident was found to have a temperature above 37.8 C, and there was no documentation until the identified shift when the resident was sent to the hospital. A late progress note documentation on the day the resident was sent to the hospital stated the resident had an identified temperature above 37.8 C and was transferred to the hospital.

Interview with PSW #109 who worked on several identified shifts during the week of that the resident was sent to the hospital, stated that the resident appeared to be their normal self and did not exhibit changes in behaviours or voice any discomfort on the shifts that they had worked.

Interview with RPN #115 stated they did not recall documenting a temperature above 37.8 C for resident #004 on the identified shift the day prior to the resident's transfer to the hospital. The RPN stated they had not received any reports from previous shifts for any particular monitoring required for resident #004. The RPN stated they had worked with resident #004 multiple times during week prior to the resident going to the hospital, and stated that there were no changes in the resident's behaviour. The RPN also stated the resident was able to communicate if they had any pain or discomfort, and the resident had not voiced any discomfort to the RPN. The RPN recalled administering resident #004 their scheduled pain medication, but had not provided PRN medication or any other treatment for resident #004 to reduce the fever, and they could not recall documenting the identified temperature above 37.8 C for resident #004. The RPN stated it was a very busy time in the home as they were the only RPN working on the floor.

Interviews with the acting DOC stated that it is the home's expectation for staff to provide PRN medication to lower fever to a resident if they have a fever, to inform the physician, and to communicate to staff on subsequent shifts and monitor the resident to treat the symptoms. There was no evidence to support that this was done for resident #004 after they had the identified temperature above 37.8C on the identified shift the day prior to

their being sent to the hospital; the resident was sent to the hospital on an identified shift the next day with an identified temperature above 37.8 C. [s. 229. (5) (b)]

Additional Required Actions:

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

Issued on this 7th 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

Ordre(s) de l'inspecteur

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

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) :	IVY LAM (646)
Inspection No. / No de l'inspection :	2020_769646_0007
Log No. / No de registre :	007598-20, 007996-20, 008042-20, 009294-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 2, 2020
Licensee / Titulaire de permis :	Rykka Care Centres LP 3760 14th Avenue, Suite 402, MARKHAM, ON, L3R-3T7
LTC Home / Foyer de SLD :	Hawthorne Place Care Centre 2045 Finch Avenue West, NORTH YORK, ON, M3N-1M9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Charlotte Altenburg

To Rykka Care Centres LP, you are hereby required to comply with the following order (s) by the date(s) set out below:

Order # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) the symptoms are recorded and that immediate action is taken as required.
O. Reg. 79/10, s. 229 (5).

Order / Ordre :

The licensee must be compliant with O. Reg 79/10, s. 229 (5).
Specifically, the licensee shall ensure that:
1) The residents' symptoms of infection are monitored every shift in accordance with evidence-based practices and, if there are non, in accordance with prevailing practices;
2) Staff on every shift record symptoms of infections and take immediate action as required;
3) All registered staff, including new and agency staff, working in the home are educated on and aware of: the process for reporting significant and reportable changes in residents with signs and symptoms of infection, to the next shift and the physician, and take immediate action as required;
4) Staff conduct audits of any residents on infection monitoring for exhibiting symptoms of infection; and
5) That a record of the training provided for staff is kept, and includes the dates the training(s) were held, names of staff who attended the training, and the dates and locations of the completed audits.

Grounds / Motifs :

1. The licensee has failed to ensure that staff monitored symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

This inspection was initiated related to a complaint received by the Ministry of Long-Term Care (MLTC) related to resident #004, who was sent to the hospital

with an identified temperature an identified date, and passed away in the hospital.

Review of the COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7, with effective date of implementation on March 30, 2020, showed that Long-term care homes must immediately implement the following precautions and procedures:

- Active Screening of all Residents. Long-term care homes must conduct active screening of all residents, at least twice daily (at the beginning and end of the day) to identify if any resident has fever, cough or other symptoms of COVID-19.

Review of resident #004’s temperature summary and progress notes on PointClickCare (PCC) for an identified 14-day period, showed that no temperature check was recorded for the resident on:
- Day and evening shifts on two identified dates,
- Day shift on one identified date, and
- Evening shifts on five identified dates.

Interview with the unit clerk showed that the home’s usual staffing complement on the identified floor that resident #004 resided were: An identified number of Personal Support Workers (PSWs) and Registered Practical Nurses (RPNs) during the day shift, and another identified number of PSWs, but the same number of RPNs for the evening shift.

Review of the home’s staffing list for the identified floor showed that the staffing level was less than the usual staffing complement on seven of the above mentioned dates for both PSWs and RPNs.

Interview with RPN #115, who worked on four shifts and had documented the administration of medication on the electronic Medication Administration Record (eMAR) for resident #004 but did not record any temperature on the four identified shifts for resident #004. They stated that it is their usual practice to take residents' temperature on day and evening shifts for all residents. However, during the identified week above, the RPN stated there were multiple shifts

where they were the only RPN on the identified floor, with very few PSWs on the floor and the staff were very busy.

Interview with RPN #106 who worked on two identified shifts in the period above, stated the registered staff should check the resident's temperature twice daily, during morning and evening shift. The RPN stated that they were new to the home at this time, and they documented what they had done on PCC. The RPN could not recall whether they had taken the resident's temperature. However, no documentation of temperature check was done on the two identified shifts that they had worked.

Interview with Assistant Director of Care (ADOC) #114 in the home, who also worked as an RN on an identified shift to administer medications to residents, stated that it was the role of the registered staff who was assigned to administer residents' medication to also do temperature checks of residents on day and evening shifts. ADOC #114 stated that on that identified shift, they were the only ADOC available, as the other two ADOCs were not working, and they also had to administer medications due to the shortage of registered staff in the home. ADOC #114 could not recall why they did not take resident #004's temperature that day, but stated it was their responsibility to take the temperature for resident #004 that day during day shift.

In interview with the IPAC lead-Clinical Practice Coordinator (CPC), they stated that it is the home's expectation to have the registered staff do two temperature checks for the resident, once during day shift and once during evening shift, in accordance with the current directives for long-term care homes. However, the IPAC lead-CPC was ill and away from the home starting on an identified date for three weeks.

Interview with the Executive Director (ED) stated that there were no complaints or concerns received regarding any issues with the availability of thermometers in the home in the identified month in question.

Interviews with the acting Director of Care (DOC) and ED stated that it was the home's expectation for staff to check and document the residents' temperatures on day and evening shifts for all residents as per current practice, and this was not done for resident #004 on the above-mentioned shifts. (646)

2. The licensee has failed to ensure that staff on every shift recorded symptoms of infection in residents and took immediate action as required.

This inspection was initiated related to multiple complaints received by the MLTC related to resident #008, who passed away in the home on an identified date.

Review of resident #008's temperature summary and progress notes on PointClickCare (PCC) for the identified month that resident passed away showed that the resident's temperature was taken twice daily for an identified period. Review of the temperature summary and progress notes showed that resident #008 had a temperature recording higher than 37.8 C twice during the period above: On the first identified date on an identified shift, RPN #103 recorded an identified elevated temperature for resident #008, and on a second identified date on an identified shift, RPN #106 recorded another identified elevated temperature for resident #008.

Review of resident #008's progress notes and eMAR on the first identified date, showed that RPN #103 provided the resident with an identified medication when necessary / pro re nata (PRN) and rechecked the temperature, encouraged fluids for the resident, and documented for the next shift to continue to monitor. Review of documentation for the next shift, showed that RPN #108 rechecked the resident's temperature twice, and the temperature was below 37.8 C. Resident #008's temperature on the shift afterward also showed a temperature below 37.8 C.

Review of resident #008's temperature summary on the second identified date showed the resident had a temperature above 37.8 C on an identified shift at an identified time. Review of the progress notes on the same day, documented at 30 minutes after the identified recorded temperature, showed that a PSW had alerted RPN #106 that resident #008 appeared unwell. The PSW was not named in the progress notes and RPN #106 could not recall who the PSW was. RPN #106 had rechecked the resident's temperature to be below 37.8 C at this point. However, RPN #106 documented that the resident's oxygen saturation level was at an identified level that was lower than normal. The RPN documented that they left the resident in their bed, and for the next shift to

continue to monitor the resident.

Review of resident #008's temperature summary for next shift showed a temperature below 37.8 C, documented at the end of shift. No documentation regarding resident's oxygen saturation level was identified for the identified shift, and no comment regarding the resident's temperature was seen in the progress notes.

Review of the eMAR did not show any documentation that PRN medication was offered to the resident on the second identified date during the identified shift when the resident had a recorded temperature of higher than 37.8 C.

Interview with RPN #103 who worked with resident #008 on three identified shifts two days prior to resident #008's passing stated the resident was their usual self, and continued to eat and drink as normal, and continued to communicate with the staff as normal.

Interview with RPN #106 stated they were new to the home and could not recall resident #008. Upon reviewing resident #008's progress notes and temperature summary, the RPN stated they could not recall if they documented the correct oxygen saturation level, or if they had provided any treatment for the resident for the elevated temperature, or to address the oxygen saturation on the second identified date. RPN #106 further stated, if the resident had a fever, they would provide PRN medication and provide a cool cloth for the resident, and if the resident's oxygen level was below 90%, they would have administered oxygen, and inform the nurse in charge and the doctor. RPN #106 further stated they would document in the progress notes the actions they took.

Interview with Agency RPN #101 who worked on an identified shift in the second identified date stated that they had only worked a few shifts in the home and could not recall resident #008. RPN #101 further stated that they were not informed by the previous shift during shift report for any particular resident to specifically monitor, and did not check any vitals, including the oxygen saturation, for the residents outside of the regular temperature check. The RPN further stated that there was no resident with elevated temperature during the shifts that they had worked. The RPN also stated that no PSW had informed them that any resident was unwell when they had worked.

Interview with PSW #102 who had found the resident unresponsive on the identified shift that the resident had passed away stated that there were very few PSWs and registered staff working at the time, and the PSW did rounds to check on residents, and found that resident #008 was in bed. When PSW #102 returned to resident #008 for care, the PSW realized the resident was not responsive when they touched their hand and face and went to get RPN #104.

Interview with RPN #104 stated that prior to the start of shift, no one had informed the RPN of any concerns for resident #008 from previous shifts. The RPN further stated that at the time, the home was very short staffed, and the RPN had to help with two floors. They further stated that they had not read that the resident had a fever or low oxygen saturation from previous shifts. The RPN stated that PSW #102 had informed them that resident #008 was in their bed and unresponsive. The RPN stated when they had arrived to see resident #008, the resident was in bed with no vital signs. The RPN then called and informed the doctor to describe what they had seen, and the doctor determined an identified cause of death.

Interviews with the acting DOC and the ED stated that if a resident has a fever, it is the home's expectation for staff to provide PRN medication to lower the resident's temperature as per the order, to inform the physician, and to communicate to staff on subsequent shifts and monitor the resident to treat the symptoms. The acting DOC and ED further stated that if a resident has low oxygen saturation, they would expect the staff to provide oxygen, notify the physician if the oxygen level does not improve, and monitor for visible signs of distress and difficulty breathing. They stated they were not certain if RPN #106 had documented the oxygen saturation level correctly on the second identified date, but action should have been taken on subsequent shifts related to the elevated temperature and documented oxygen level identified on the second identified date, and this was not done for resident #008. (646)

3. This inspection was initiated related to a complaint received by the MLTC related to the death of resident #004, who was sent to the hospital with an identified temperature above 37.8 C on an identified date and passed away in the hospital four days later.

Review of resident #004's temperature summary showed that RPN #115 had documented that resident #004 had a temperature above 37.8 C at the end of the shift, two shifts prior to the resident being sent to the hospital. No other documentation was found on the temperature summary for resident #004 on that identified shift.

Review of resident #004's eMAR on the identified shift showed that RPN #115 provided the resident their identified regular medication, but did not administer the resident's PRN medication on the identified shift when the resident had an identified temperature above 37.8 C.

Review of the progress notes did not show any documentation on the identified shift when the resident was found to have a temperature above 37.8 C, and there was no documentation until the identified shift when the resident was sent to the hospital. A late progress note documentation on the day the resident was sent to the hospital stated the resident had an identified temperature above 37.8 C and was transferred to the hospital.

Interview with PSW #109 who worked on several identified shifts during the week of that the resident was sent to the hospital, stated that the resident appeared to be their normal self and did not exhibit changes in behaviours or voice any discomfort on the shifts that they had worked.

Interview with RPN #115 stated they did not recall documenting a temperature above 37.8 C for resident #004 on the identified shift the day prior to the resident's transfer to the hospital. The RPN stated they had not received any reports from previous shifts for any particular monitoring required for resident #004. The RPN stated they had worked with resident #004 multiple times during week prior to the resident going to the hospital, and stated that there were no changes in the resident's behaviour. The RPN also stated the resident was able to communicate if they had any pain or discomfort, and the resident had not voiced any discomfort to the RPN. The RPN recalled administering resident #004 their scheduled pain medication, but had not provided PRN medication or any other treatment for resident #004 to reduce the fever, and they could not recall documenting the identified temperature above 37.8 C for resident #004. The RPN stated it was a very busy time in the home as they were the only RPN working on the floor.

Interviews with the acting DOC stated that it is the home's expectation for staff to provide PRN medication to lower fever to a resident if they have a fever, to inform the physician, and to communicate to staff on subsequent shifts and monitor the resident to treat the symptoms. There was no evidence to support that this was done for resident #004 after they had the identified temperature above 37.8C on the identified shift the day prior to their being sent to the hospital; the resident was sent to the hospital on an identified shift the next day with an identified temperature above 37.8 C.

The severity of this issue was determined to be a level 2 as there was minimal harm or minimal risk to residents #003 and #004. The scope of the issue was a level 2 as it related to two of four residents reviewed. The home had a level 2 compliance history as they had previous non-compliance to a different subsection of the LTCHA that included:
- Written Notice (WN) issued under r. 229 (4) Infection Prevention and Control, on December 13, 2019 (2018_642698_0006). (646)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 05, 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 2nd day of July, 2020

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Ivy Lam

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