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 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
Apr 10, 2017	2017_302600_0003	028794-15, 027084-16, 028101-16	Complaint

Licensee/Titulaire de permis

COPERNICUS LODGE
66 RONCESVALLES AVENUE TORONTO ON M6R 3A7

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

COPERNICUS LODGE
66 RONCESVALLES AVENUE TORONTO ON M6R 3A7

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): January 23, 24, 25, 26, 27, 30, 31 and February 1, 3, 2017.

During the course of the inspection complaints #028794-15, regarding infection prevention and control, medication administration, plan of care-assessments, duty to protect, responsive behaviour, continence care; #027084-16 duty to protect and continence care; and #028101-16, regarding plan of care, falls prevention, skin and wound care, duty to protect, transferring and positioning, Residents' Bill of Rights, and reporting and complaints, were inspected.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Assistant Director of Care (ADOC), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), physiotherapist (PT), substitute decision maker (SDM), and family members.

The inspector conducted a tour of the home, observations of the provision of care, staff and resident interactions, and medication administration, record review of resident's health records, staffing schedules, reviewed the home's complaint documentation and critical incidents records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

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

- **6 WN(s)**
- **3 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	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 are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

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 a complaint submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, revealed complainant's concerns that resident #001's needs were not being met and he/she was being neglected in a couple months in 2015. Resident #001 was not provided with treatment immediately after the change in resident's condition had been identified.

Review of resident #001's plan of care revealed that the resident was admitted in the home on an identified date with multiple medical diagnosis.

Review of the resident's written plan of care indicated that the resident was prone to the identified medical condition and one of the interventions to prevent that medical condition was staff to provide identified diagnostic tests.

Review of the resident's plan of care including progress notes, laboratory results and doctor's orders for the identified months in 2015, revealed:
- On a specified date resident #001's substitute decision maker (SDM) requested an identified test to be performed to the resident.
- The test was conducted and the results were sent to the home the following day. The test revealed positive results.

- On the following identified date, review of the resident #001’s progress notes revealed that the resident experienced some changes in a health condition, so the staff called the SDM to assist with managing resident #001. The nurse discovered that the resident's test came back for positive result after the SDM requested to see the result of the test. Then the staff notified the physician and obtained prescription for treatment.

Interview with ADOC confirmed the practice in the home was if the result was positive, the laboratory would call the home by phone and report the results the same or the following day of the test and the registered staff are to immediately notify the physician about the positive results. The ADOC stated that he/she was not aware that the physician was not notified immediately on the identified date for the positive result of the resident #001 who was prone to that medical condition.

Further review of the progress notes and medication administration record indicated the resident completed a course of treatment on a specified date but the resident continued to have symptoms of the medical condition that characterized that condition.

Interview with ADOC indicated that the process in the home for any resident who received treatment for the identified medical condition a follow up the test would be conducted three to four days after completion of the treatment for monitoring of the effect of the treatment.

Further review of the progress notes revealed that on another identified date, four days after the resident completed the course of the treatment, the resident's care conference had been held and the team had decided the resident to have specified test every second week. However the test was not conducted right away when they decided to have a regular test, but it was conducted a week after the decision.

On a specified date when SDM visited the resident and observed resident #001's increased change in condition, the SDM requested a additional test to be conducted to rule out general change of the condition. The physician ordered the test and it had been scheduled for a specified date.

The specified test was conducted 11 days after completion of the course of the treatment and it came back positive for presence of two identified triggers. The physician was not notified the same day, but the following day and two different type of treatments were ordered.

Review of the progress notes from a specified date revealed that the SDM requested not to start the treatments until the additional test results come back. However the additional test had not been conducted at all.

Interview with ADOC confirmed that the additional test was not conducted because when the home called the laboratory on the date when the resident was to have the test, the laboratory told the home that this kind of test was conducted only in a hospital setting, not in the nursing homes. This information was not passed to the SDM, and the decision for holding off the treatments was not reviewed.

Further review of resident #001's progress notes for the following month, revealed that the resident continued to experience classical symptoms of the medical condition which also was noted by the SDM when he/she visited resident on an identified date. The progress notes revealed that at that time the SDM acknowledged that the resident had not started the treatment ordered 10 days ago. The SDM called an ambulance and resident #001 was transferred to the hospital where he/she was admitted and diagnosed for worsened medical condition.

Interview with SDM confirmed that he/she had not been notified that the additional test had not been conducted at all and he/she was not contacted to review his/her decision about resident #001's treatment.

Interview with ADOC, PSWs #108, #109, #111, RPNs #115, #110, and #107 confirmed that the team was aware of resident #001's health condition. He/she was at high risk for specified medical condition especially with change in his/her health status.

Interview with ADOC also confirmed that in case of resident #001, the registered nurse who received the results on an identified date should have notified the physician that there were positive results so resident would have started with the treatment as soon as possible. Further, the ADOC confirmed the resident should be followed up after completion of the treatment, and the test should have been conducted. He/she was not able to explain why the SDM was not notified that additional test work was not conducted. The ADOC also confirmed that there must have been a miss communication with the SDM so the resident had not started the treatments for 10 days after the physician had ordered it.

The scope was identified to be isolated to one resident; severity was identified to be actual harm as resident #001's health condition worsened as a result of not receiving

immediate treatment when the causes were identified by the test. Due to the severity of actual harm to resident #001, a compliance order is warranted. [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 LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee had immediately forwarded any written complaints concerning the care of a resident or the operation of the home to the Director.

Review of a complaint revealed that the complainant had submitted a written complaint to the DOC on two identified dates but that complaints were not forwarded to the Director immediately. Both complaints with the investigation were forwarded to the Director ten days after the second complaint was submitted to the DOC.

Interview with complainant revealed a second complaint was submitted to the home on an identified date and the home was notified that the complaint would be submitted to the MOHLTC as well. Further the complainant indicated that he/she had submitted complaints to the home regarding concerns of his/her mom's care five times in 2015 and three times in 2016, that were not responded.

Interview with DOC confirmed that the home was aware of reporting the complaint to the MOHLTC but they did not report as they worked on the investigation and wanted to report once they completed their investigation. [s. 22. (1)]

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 the licensee immediately forward any written complaints that have been received concerning the care of a resident or the operation of the home to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Review of a complaint submitted to the MOHLTC on an identified date revealed that the substitute decision maker (SDM) stated resident #001 had sustained injury. SDM states on many occasions he/she has found resident #001 with identified responsive behaviour on multiple occasions and questions whether or not the staff were monitoring the resident.

Review of resident #001's plan of care revealed that resident was admitted to the home on an identified date. He/she had been identified to be at risk for change in her condition as he/she had history prior the admission to the home due to changes in condition and use of treatment. Further the review of the resident written plan of care revealed that the resident had interventions in place to prevent the change in condition. The review of resident #001's plan of care also revealed that the resident was mobile with assistance of device and had been participating in a program to enhance his/her mobility. However,

due to his/her change in condition, resident #001 was often found not using the device for transferring or ambulation.

Review of resident #001 progress notes revealed that resident had an un-witnessed incident on an identified date, when he/she had been ambulating. Post incident assessment revealed that resident #001 had change in condition and sustained injury. The resident was assessed and transferred for further assessment and treatments. The resident returned with identified diagnosis.

Review of resident #001's assessment record for 2016, indicated that resident had numerous incident assessments for period of identified time in 2016, when he/she was discharged to another facility.

Review of the progress notes for the above mentioned period revealed that the staff was aware of the resident being at risk for injury and despite applying all the interventions in place, the resident still had incidents.

Review of resident #001's plan of care failed to reveal if the interventions and the resident's responses to interventions were documented.

Interview with DOC revealed that when resident experiences some incidents, the resident is referred to the interdisciplinary prevention team and they review the intervention and the resident's responses to the intervention. However, the DOC confirmed that interdisciplinary prevention team failed to document the resident #001's response to the interventions and implementation of new interventions. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff participated in the implementation of the infection prevention and control program.

Review of a complaint submitted to the MOHLTC on an identified date revealed a complainant having concerns regarding home not participating in one of the mandatory programs. The complainant stated he/she had observed resident #001's equipment for personal care and staff equipment for treatment to be left on the floor in residents' washrooms on many occasions. That made complainant concerns as the resident was at high risk for medical condition and on a couple occasions conducted tests were unsuccessful.
On an identified date, inspector #600 observed some equipment left on the floor in identified residents' rooms.

Interview with the PSW #123, #121, #122 and RPN #124 confirmed those residents' items should not be on the floor as the home has a designated spot where residents' items should be placed after they are used and cleaned.

Interview with the director of care (DOC) confirmed the staff is expected to practice IPAC every time they provide care to the residents when they are in residents' rooms. The DOC confirmed the staff should not leave the personal hygiene item on the floor after they have used and cleaned them.

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 the staff participated in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Review of a complaint submitted to the MOHLTC on an identified date revealed the complainant had identified that resident's skin to be altered on different areas, but no assessment or treatment had been provided.

Review of the resident's progress notes revealed on an identified date the complainant noticed that the resident had altered skin integrity to identified areas of the body. On another identified date while providing care to the resident, the complainant had reported to the staff that the resident's had impaired skin integrity on a specific area of the body. On third identified date, the complainant identified one more impaired skin integrity and reported to the nurse.

Review of the resident's assessments records revealed that the resident exhibiting altered skin integrity had not received a skin assessment for the identified areas by a registered nursing staff, using a clinically appropriate assessment tool that is specifically designed for skin and wound assessment.

Review of the resident's written plan of care failed to reveal that resident had been assessed for altered skin integrity and there were no planned interventions to prevent skin alteration.

Interview with DOC confirmed the resident did not received assessment when he/she exhibited skin alteration. Further the DOC confirmed he/she was not aware that resident had altered skin integrity, but the home expects the registered staff to assess the resident skin 24 hours in admission, after hospitalization or leave of absence and when staff identified altered skin integrity. [s. 50. (2) (b) (i)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint. For the complaint that cannot be investigated and resolved within 10 business days has an acknowledgement been provided within 10 business days of receipt of the complaint, including the date by which the complainant can reasonably expect a resolution.

Review of a complaint submitted to the MOHLTC on an identified date revealed that the complainant stated he/she had submitted a written complaint to the DOC on an identified date, but he/she did not receive response and the complaint was not reported to the MOHLTC. Further the complainant stated that he/she had submitted his/her concerns/complaints to the chief executive officer on another identified date but he/she had not responded back to the complainant until ten days after when the complainant submits his/her complaints to the MOHLTC.

Interview with the complainant confirmed that the home did not respond him/her on the first complaint submitted on an identified date until when he she submitted the second complain, when he/she notified the home that will submit another complaint to the MOHLTC.

Review of the home Reporting and Complaints records indicated there were two written complaint forms completed by the complainant on both dates. Further record review indicated that there was a letter submitted to the MOHLTC on an identified date in 2016, that identified the complaints and the home's response to the two complaints from the complainant that have been submitted on both dates. Further record review failed to reveal any correspondence with the complainant after the first complaint 2016.

Interview with DOC confirmed that the home had been late to respond to the complainant on the first complaint within 10 business day due to the length and complicated investigation they had to conduct. Further the DOC confirmed that they had communicated with the complainant when he/she visit the resident but they have not provided him/her with acknowledgement about the complaint. [s. 101. (1) 2.]

Issued on this 10th day of May, 2017

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

Ministére 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) :	GORDANA KRSTEVSKA (600)
Inspection No. / No de l'inspection :	2017_302600_0003
Log No. / Registre no:	028794-15, 027084-16, 028101-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 10, 2017
Licensee / Titulaire de permis :	COPERNICUS LODGE 66 RONCESVALLES AVENUE, TORONTO, ON, M6R-3A7
LTC Home / Foyer de SLD :	COPERNICUS LODGE 66 RONCESVALLES AVENUE, TORONTO, ON, M6R-3A7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Catherine Kowalenko

To COPERNICUS LODGE, you are hereby required to comply with the following order (s) by the date(s) set out below:

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

Ministére 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

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 :

Upon receipt of this compliance order the licensee will:
i. Ensure that for residents identified to obtain a specified medical condition and demonstrating responsive behaviours, strategies are developed and implemented to ensure the residents' physical health status is assessed; and
ii. Ensure there is a process in place so that the communication within the intradisciplinary team, including the family members, is forthwith, constant, and two ways communication.

Grounds / Motifs :

1. The licensee has failed to ensure that the residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

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 a complaint submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, revealed complainant's concerns that resident #001's needs were not being met and he/she was being neglected in a couple months in 2015. Resident #001 was not provided with treatment immediately after the change in resident's condition had been identified.

Review of resident #001's plan of care revealed that the resident was admitted in the home on an identified date with multiple medical diagnosis.

Review of the resident's written plan of care indicated that the resident was prone to the identified medical condition and one of the interventions to prevent that medical condition was staff to provide identified diagnostic tests.

Review of the resident's plan of care including progress notes, laboratory results and doctor's orders for the identified months in 2015, revealed:
- On a specified date resident #001's substitute decision maker (SDM) requested an identified test to be performed to the resident.
- The test was conducted and the results were sent to the home the following day. The test revealed positive results.
- On the following identified date, review of the resident #001's progress notes revealed that the resident experienced some changes in a health condition, so the staff called the SDM to assist with managing resident #001. The nurse discovered that the resident's test came back for positive result after the SDM requested to see the result of the test. Then the staff notified the physician and obtained prescription for treatment.

Interview with ADOC confirmed the practice in the home was if the result was positive, the laboratory would call the home by phone and report the results the same or the following day of the test and the registered staff are to immediately notify the physician about the positive results. The ADOC stated that he/she was not aware that the physician was not notified immediately on the identified date for the positive result of the resident #001 who was prone to that medical condition.

Further review of the progress notes and medication administration record indicated the resident completed a course of treatment on a specified date but the resident continued to have symptoms of the medical condition that characterized that condition.

Interview with ADOC indicated that the process in the home for any resident who received treatment for the identified medical condition a follow up the test would be conducted three to four days after completion of the treatment for monitoring of the effect of the treatment.

Further review of the progress notes revealed that on another identified date, four days after the resident completed the course of the treatment, the resident's care conference had been held and the team had decided the resident to have specified test every second week. However the test was not conducted right

away when they decided to have a regular test, but it was conducted a week after the decision.

On a specified date when SDM visited the resident and observed resident #001's increased change in condition, the SDM requested a additional test to be conducted to rule out general change of the condition. The physician ordered the test and it had been scheduled for a specified date.

The specified test was conducted 11 days after completion of the course of the treatment and it came back positive for presence of two identified triggers. The physician was not notified the same day, but the following day and two different type of treatments were ordered.

Review of the progress notes from a specified date revealed that the SDM requested not to start the treatments until the additional test results come back. However the additional test had not been conducted at all.

Interview with ADOC confirmed that the additional test was not conducted because when the home called the laboratory on the date when the resident was to have the test, the laboratory told the home that this kind of test was conducted only in a hospital setting, not in the nursing homes. This information was not passed to the SDM, and the decision for holding off the treatments was not reviewed.

Further review of resident #001's progress notes for the following month, revealed that the resident continued to experience classical symptoms of the medical condition which also was noted by the SDM when he/she visited resident on an identified date. The progress notes revealed that at that time the SDM acknowledged that the resident had not started the treatment ordered 10 days ago. The SDM called an ambulance and resident #001 was transferred to the hospital where he/she was admitted and diagnosed for worsened medical condition.

Interview with SDM confirmed that he/she had not been notified that the additional test had not been conducted at all and he/she was not contacted to review his/her decision about resident #001's treatment.

Interview with ADOC, PSWs #108, #109, #111, RPNs #115, #110, and #107 confirmed that the team was aware of resident #001's health condition. He/she

was at high risk for specified medical condition especially with change in his/her health status.

Interview with ADOC also confirmed that in case of resident #001, the registered nurse who received the results on an identified date should have notified the physician that there were positive results so resident would have started with the treatment as soon as possible. Further, the ADOC confirmed the resident should be followed up after completion of the treatment, and the test should have been conducted. He/she was not able to explain why the SDM was not notified that additional test work was not conducted. The ADOC also confirmed that there must have been a miss communication with the SDM so the resident had not started the treatments for 10 days after the physician had ordered it.

The scope was identified to be isolated to one resident; severity was identified to be actual harm as resident #001's health condition worsened as a result of not receiving immediate treatment when the causes were identified by the test. Due to the severity of actual harm to resident #001, a compliance order is warranted. [s. 19. (1)] (600)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 24, 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 10th day of April, 2017

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