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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 13, 2016	2016_514566_0017	029563-16	Resident Quality Inspection

Licensee/Titulaire de permis

2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 INVESTMENT LP
302 Town Centre Blvd. Suite #200 MARKHAM ON L3R 0E8

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

Muskoka Shores Care Community
200 KELLY DRIVE GRAVENHURST ON P1P 1P3

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

ARIEL JONES (566), NATALIE MOLIN (652), SARAH KENNEDY (605)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 6, 7, 11, 12, 13, 14, 17, 18, 19, 20, 21, 24, 25, 26, 31, November 1, and 2, 2016.

The following critical incident (CI) inspections were conducted concurrently with the RQI: 004146-15, 027641-15, and 023877-16 (related to falls); and 016259-16 (related to improper treatment).

The following complaint inspections were conducted concurrently with the RQI: 012089-16 (related to restorative care, skin and wound care, pain management, and plan of care); and, 017042-16 (related to abuse/neglect and plan of care) and 020897 -16 (related to medication) completed under separate report number 2016_398605_0020.
Findings of non-compliance identified under the Long-Term Care Homes Act, 2007 s. 6(4)(b) and s. 6(7) related to resident #023 from inspection #2016_398605_0020 were issued together with the non-compliances of this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, directors of care (DOC), associate directors of care (ADOC), physicians (MD), pharmacists, registered dietitian (RD), physiotherapist (PT), physiotherapist's assistant (PTA), director of resident programs, environmental services manager (ESM), director of resident services, director of dietary services (DDS), Vital Aire representative, registered nursing staff, personal support workers (PSWs), dietary aide, Residents' Council president and Family Council representative, residents, substitute decision makers (SDMs), and complainants.

During the course of the inspection, the inspector(s): conducted a tour of the home; observed meal service, medication administration, staff to resident interactions and the provision of care, resident to resident interactions; and reviewed resident health care records, staff training records, meeting minutes for Residents' Council and Family Council, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_298557_0004	605

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for resident #030 that set out clear directions to staff and others who provided direct care to the resident.

A review of a critical incident report (CIR) submitted on an identified date in May 2016, revealed PSW #136 did not apply the required supplementary therapy for resident #030 when he/she got the resident up for a meal or when he/she returned the resident to bed after the meal. Resident #030's health status changed and he/she passed away later on the same day.

A review of the resident's written plan of care and kardex, as of an identified date in May 2016, failed to include information for direct care staff regarding the resident's outlined identified supplementary therapy treatment and interventions.

An interview with PSW #136 was attempted, however, the PSW was unable to be reached.

Interviews with RPN #138 and DOC #101 confirmed there was nothing in resident #030's written plan of care regarding the identified supplementary therapy. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A review of a CIR submitted on an identified date in May 2016, revealed PSW #136 did not apply an identified supplementary treatment required for resident #030 when he/she got the resident up for a meal or when he/she returned the resident to bed after the meal. Resident #030's health status changed and he/she passed away later on the same day.

A review of resident #030's healthcare records revealed that an assessment was completed on an identified date in February 2016 by an identified contracted service representative #139. He/She left recommendations to increase resident #030's supplementary therapy by a specific amount on a routine basis, and to apply to the Ministry of Health and Long-Term Care (MOHLTC) for additional funding for the identified supplementary therapy for the resident. A review of resident #030's application for funding from the same date in February 2016, revealed the prescription in the application was for an identified increase in the supplementary therapy for an indefinite time period. This application was signed by MD #140, however there was no documented evidence in resident #030's healthcare record that the identified prescription was applied to resident #030 as per the consultant's recommendations. A review of resident #030's medication administration records (MARs) from February 2016 to May 2016, confirmed that the specific recommendation made by the contracted service representative in February 2016 to increase the identified supplementary treatment and provide routine therapy was not implemented.

A review of the resident's health care record revealed resident #030 had a physician's order to maintain an identified vital sign above a specific level using an identified supplementary therapy intermittently, as needed. There was no documented evidence in resident #030's health care records to reflect that the registered staff continued to re-assess the resident's identified vital signs to ensure they were above the specified level, as prescribed by the physician (MD). A review of the the resident's death records revealed that resident #030's cause of death was due to an identified medical diagnosis.

An interview with contracted service representative #139 revealed that he/she received a referral and conducted a specific assessment for resident #030 on an identified date in February 2016. He/She then left the assessment in the resident's chart and failed to communicate the information to the home's nursing staff. An interview with MD #140 revealed that he/she did not recall how he/she received the application form for the additional MOHLTC funding for the identified supplementary therapy, however, confirmed it was his/her signature on the form.

Interviews with RPN #138 and RN #137 revealed further that they were not aware of the assessment completed for resident #030 by the contracted service representative in February 2016, and that resident #030 had not been prescribed routine supplementary therapy as per the assessment recommendations. An interview with pharmacist #135 confirmed resident #030 did not have an order for routine therapy and the order in place at the time of death on an identified date in May 2016 was to maintain the identified vital sign above a specific level using an identified amount of supplementary therapy intermittently, as needed.

An interview with ADOC #105 confirmed that a client referral and assessment was completed by an identified contracted service representative on an identified date in February 2016, and that the recommendation from the identified assessment was not implemented.

Interviews with ADOC #105 and DOC #101 confirmed that staff and others involved in the different aspects of the resident's identified supplementary therapy care did not collaborate with each other in the assessment of resident #030. [s. 6. (4) (a)]

3. The following non-compliance is in relation to findings identified under complaint inspection #2016_398605_0020, which was conducted concurrently with this inspection.

The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

Resident #023 was admitted to the home on an identified date in April 2016. Record review revealed the resident had a specific medical diagnosis. Interviews with substitute decision maker (SDM) #118 and physician #112 revealed the resident was receiving the an identified medication for the identified medical condition prior to admission.

A review of resident #023's new admission order form revealed the prescribed medication was put on hold on admission. Further review of resident #023's records and interviews with RN #117 and RPN #116 revealed a physician order from an identified date in April 2016 for the identified medication was on hold until the pharmacy provided information on safety precautions for the medication and the safety precautions were implemented in the home.

An interview with DOC #113 revealed he/she became aware of the staff's safety concerns around the identified medication when consultant pharmacist #114 forwarded training materials on this specific class of medications to the home one week after the resident's admission. DOC #113 confirmed the consultant pharmacist sent the education materials on the safety precautions for administering the identified medication, and the education was shared with the registered practical nurses and registered nurses on an unidentified date prior to the date the resident received his/her first dosage of the identified medication in May 2016.

A review of resident #023's MAR for May 2016, and an interview with RPN #116 both revealed resident #023 received the first dose of the identified medication on an identified date in May 2016.

An interview with ADOC #105 revealed resident #023's prescribed medication was held on admission and the first dose was not administered to the resident until an identified date in May 2016, one month after resident #023's admission to the home. Registered nursing staff together with management at the home failed to collaborate on the implementation of the resident's plan of care so that resident #023 received his/her medication when information on safety precautions for the identified medication was received by the home and the staff education conducted. [s. 6. (4) (b)]

4. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A review of a critical incident report (CIR) submitted on an identified date in May 2016, revealed PSW #136 did not apply the required supplementary therapy for resident #030 when he/she got the resident up for a meal or when he/she returned the resident to bed after the meal. Resident #030's health status changed and he/she passed away later on the same day.

A review of resident #030’s progress notes from an identified date and time in May 2016, revealed the resident's identified vital sign had decreased to below the recommended level. Registered practical nurse (RPN) #141 applied the supplementary therapy at a specific rate to resident #030 which increased his/her vital sign value, however, it remained below the recommended level. Record review revealed resident #030 had a prescribed physician’s order to maintain the identified vital sign measurement above a specific value using an identified level of supplementary therapy intermittently, as needed. There was no documented evidence in resident #030’s health care records to reflect that the registered staff continued to re-assess the resident’s vital signs to ensure they were above the recommended value, as prescribed by the physician (MD). A review of the resident’s written plan of care and kardex from a specific date in May 2016, failed to include information for direct care staff regarding the resident’s outlined supplementary therapy treatment and interventions.

A review of resident #030’s progress notes from a second identified date and time in May 2016, one day later, revealed resident #030 was taken to the dining room for an identified meal without his/her supplementary therapy applied. The resident’s identified vital sign decreased to a specific level below the MD's recommendation. RPN #138 then applied supplementary therapy at an identified rate to the resident while in the dining room and his/her identified vital sign increased, however, remained below the recommended level. During this time, resident #030 was noted by staff to appear lethargic. RN #137 assessed resident #030 at an identified time and he/she was noted to require the supplementary therapy in order to maintain his/her identified vital sign above the recommended level. There was no documentation in resident #030’s healthcare record to support the resident was put on continuous monitoring to ensure his/her identified vital signs remained above the specific level, as per the physician’s orders. After the identified meal the resident was returned to bed by PSW #136.

Approximately one hour after RN #137's assessment, MD #133 discovered resident #030 lying in bed without his/her supplementary therapy applied and displaying specific related symptoms. Resident #030 was pronounced dead shortly thereafter. A review of the resident's death records revealed that resident #030's cause of death was due to an identified medical diagnosis.

A review of the home's internal investigation notes from a third identified date in May 2016, three days after the resident's death, revealed RN #137 was paged by MD #133 on the identified incident date to resident #030’s room. When he/she arrived, the resident was displaying specific symptoms. MD #133 informed RN #137 that he/she received the

resident in bed without his/her identified supplementary therapy applied and he/she noted the treatment source was on the other side of the room. Investigation notes revealed further that the unit staff were made aware during morning report earlier on the same date that the resident's specific vital sign value had decreased and resident #030 required the identified supplementary therapy.

An interview with RN #137 confirmed that on the identified incident date in May 2016, he/she was paged by the physician regarding resident #030's health status. Upon entering the resident’s room he/she observed that resident #030's supplementary therapy had not been applied, the resident was displaying specific related symptoms, and passed away shortly thereafter. RN #137 also stated PSW #136 failed to apply the supplementary therapy for resident #030 when he/she returned the resident to bed, and the treatment source was noted to be in a location at a distance from the resident. RN #137 confirmed that he/she did not instruct PSW #136 to reapply the resident’s supplementary therapy after returning him/her to bed, but indicated the PSW should have been aware that the resident required the identified supplementary therapy.

An interview with RPN #138 revealed PSW #136 did not apply resident #030's supplementary therapy when the resident was going to the dining room for an identified meal and when the resident was transferred back to bed on the identified incident date in May 2016. RPN #138 indicated it was the expectation that PSW #136 would apply the supplementary therapy to resident #030 when he/she took the resident to the dining room and when he/she transferred the resident back to bed. RPN #138 also confirmed he/she did not go back to resident #030’s room after breakfast to ensure the resident’s supplementary therapy was applied and working.

An interview with PSW #136 was attempted, however, the PSW was unable to be reached.

An interview with physician #133 confirmed that when he/she entered resident #030's room on the identified incident date in May 2016, the resident's supplementary therapy was not applied and the resident was displaying specific related symptoms.

Interviews with ADOC #105 and DOC #101 confirmed that resident #030's identified supplementary therapy was not provided as specified in the resident's plan of care.

The scope of this non-compliance is isolated as it relates to one resident. The severity of harm and risk of harm to residents arising from the non-compliance resulted in actual

harm/risk. The home's Compliance History Report reveals a voluntary plan of correction (VPC) was issued in February 2016 in report 2016_298557_0003. As a result of the scope, severity and the licensee's previous compliance history, a compliance order is warranted. [s. 6. (7)]

5. The following non-compliance is in relation to findings identified under complaint inspection #2016_398605_0020, which was conducted concurrently with this inspection.

A review of resident #023’s initial nutrition assessment from an identified date in April 2016, revealed the resident had an intolerance to three identified food items. A review of the resident's written plan of care revealed resident #023 was not to be served the identified food items.

An interview with resident #023's SDM revealed he/she had observed resident #023 receiving these food items during identified meals.

A review of resident #023’s progress notes revealed he/she was given one of the specific food items at dinner on an identified date in April 2016.

An interview with the director of dietary services (DDS) confirmed the expectation is for residents with dietary restrictions to not receive the restricted foods. Care was not provided to resident #023 as specified in the plan. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 the following:
- that there is a written plan of care for residents that sets out clear directions to staff and others who provide direct care to the resident,
- that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, and
- that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: 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 all staff participate in the implementation of the infection prevention and control program (IPAC).

Infection control concerns in the resident tub and shower rooms were observed on the following dates and times:

First Floor -
South Tub Room:
October 6, 2016 at 1200h - Unlabeled drug-store brand deodorant, body cream, and two tubes of toothpaste;

South Shower Room:
October 6, 2016 at 1200h - unlabeled silver hairbrush containing strands of hair on storage rack; unlabeled silver hairbrush containing strands of hair in the sink;
October 18, 2016 at 1500h - one unlabeled silver and black coloured hairbrush containing strands of hair in the sink;

North Tub Room:
October 6, 2016 at 1200h - multiple bottles of unlabeled drug-store brand shampoos/body lotion/body wash on top of care cart; unlabeled pink hairbrush with strands of hair on top of care cart; and
October 20, 2016 at 1710h - one unlabeled black hair pick containing multiple strands of hair on top of the toilet.

Second Floor -
South Tub Room:
October 6, 2016 at 1220h - Unlabeled neck brace hanging on grab bar beside toilet; unlabeled bottle of Vitarub in sink; unlabeled nail clippers (appear used) on top of caddy; one hair elastic containing hair wrapped around it on top of towel/linen rack; one unlabeled men's plastic razor (appears used); one unlabeled pair of nail clippers and small scissors; unlabeled men's Phillips electric razor; multiple bottles of unlabeled drug-store brand shampoo on the supply cart beside tub; and,
October 20, 2016 at 1655h and October 21, 2016 at 1021h - one unlabeled pair of nail clippers and small scissors (appear used); three hair elastics containing strands of hair; two unlabeled hair barrettes sitting on top of the linen rack.

Interviews with PSW #121, PSW #122, and RPN #123 revealed that there is a process for labeling resident's personal care equipment, that all resident's personal care equipment should be labeled and properly stored in the resident's care caddies, and that any unlabeled personal care equipment in the tub and shower rooms should be disposed of as it could be considered an infection control risk.

An interview with ADOC #105 confirmed that as per the home's IPAC practices, all personal care items in tub and shower rooms should be labeled to minimize the risk of cross-contamination, and all staff are expected to participate in the IPAC program. [s. 229. (4)]

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

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Issued on this 19th day of December, 2016

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) :	ARIEL JONES (566), NATALIE MOLIN (652), SARAH KENNEDY (605)
Inspection No. / No de l'inspection :	2016_514566_0017
Log No. / Registre no:	029563-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 13, 2016
Licensee / Titulaire de permis :	2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 INVESTMENT LP 302 Town Centre Blvd., Suite #200, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Muskoka Shores Care Community 200 KELLY DRIVE, GRAVENHURST, ON, P1P-1P3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Angela Coutts

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

To 2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 INVESTMENT LP, 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. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the care set out in the plan of care for all residents receiving an identified supplementary therapy is provided as specified in the residents' plan of care. The plan shall include the development and implementation of a system of ongoing monitoring to ensure that a resident's outlined supplementary therapy treatment and interventions are performed as per the resident's plan of care.

This plan is to be submitted via email to inspector natalie.molin@ontario.ca by December 30, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A review of a critical incident report (CIR) submitted on an identified date in May 2016, revealed PSW #136 did not apply the required supplementary therapy for resident #030 when he/she got the resident up for a meal or when he/she returned the resident to bed after the meal. Resident #030's health status changed and he/she passed away later on the same day.

A review of resident #030's progress notes from an identified date and time in May 2016, revealed the resident's identified vital sign had decreased to below the recommended level. Registered practical nurse (RPN) #141 applied the supplementary therapy at a specific rate to resident #030 which increased his/her vital sign value, however, it remained below the recommended level. Record review revealed resident #030 had a prescribed physician's order to maintain the identified vital sign measurement above a specific value using an

identified level of supplementary therapy intermittently, as needed. There was no documented evidence in resident #030's health care records to reflect that the registered staff continued to re-assess the resident's vital signs to ensure they were above the recommended value, as prescribed by the physician (MD). A review of the resident's written plan of care and kardex from a specific date in May 2016, failed to include information for direct care staff regarding the resident 's outlined supplementary therapy treatment and interventions.

A review of resident #030's progress notes from a second identified date and time in May 2016, one day later, revealed resident #030 was taken to the dining room for an identified meal without his/her supplementary therapy applied. The resident's identified vital sign decreased to a specific level below the MD's recommendation. RPN #138 then applied supplementary therapy at an identified rate to the resident while in the dining room and his/her identified vital sign increased, however, remained below the recommended level. During this time, resident #030 was noted by staff to appear lethargic. RN #137 assessed resident #030 at an identified time and he/she was noted to require the supplementary therapy in order to maintain his/her identified vital sign above the recommended level. There was no documentation in resident #030's healthcare record to support the resident was put on continuous monitoring to ensure his/her identified vital signs remained above the specific level, as per the physician's orders. After the identified meal the resident was returned to bed by PSW #136.

Approximately one hour after RN #137's assessment, MD #133 discovered resident #030 lying in bed without his/her supplementary therapy applied and displaying specific related symptoms. Resident #030 was pronounced dead shortly thereafter. A review of the resident's death records revealed that resident #030's cause of death was due to an identified medical diagnosis.

A review of the home's internal investigation notes from a third identified date in May 2016, three days after the resident's death, revealed RN #137 was paged by MD #133 on the identified incident date to resident #030's room. When he/she arrived, the resident was displaying specific symptoms. MD #133 informed RN #137 that he/she received the resident in bed without his/her identified supplementary therapy applied and he/she noted the treatment source was on the other side of the room. Investigation notes revealed further that the unit staff were made aware during morning report earlier on the same date that the resident's specific vital sign value had decreased and resident #030 required

the identified supplementary therapy.

An interview with RN #137 confirmed that on the identified incident date in May 2016, he/she was paged by the physician regarding resident #030's health status. Upon entering the resident's room he/she observed that resident #030's supplementary therapy had not been applied, the resident was displaying specific related symptoms, and passed away shortly thereafter. RN #137 also stated PSW #136 failed to apply the supplementary therapy for resident #030 when he/she returned the resident to bed, and the treatment source was noted to be in a location at a distance from the resident. RN #137 confirmed that he/she did not instruct PSW #136 to reapply the resident's supplementary therapy after returning him/her to bed, but indicated the PSW should have been aware that the resident required the identified supplementary therapy.

An interview with RPN #138 revealed PSW #136 did not apply resident #030's supplementary therapy when the resident was going to the dining room for an identified meal and when the resident was transferred back to bed on the identified incident date in May 2016. RPN #138 indicated it was the expectation that PSW #136 would apply the supplementary therapy to resident #030 when he/she took the resident to the dining room and when he/she transferred the resident back to bed. RPN #138 also confirmed he/she did not go back to resident #030's room after breakfast to ensure the resident's supplementary therapy was applied and working.

An interview with PSW #136 was attempted, however, the PSW was unable to be reached.

An interview with physician #133 confirmed that when he/she entered resident #030's room on the identified incident date in May 2016, the resident's supplementary therapy was not applied and the resident was displaying specific related symptoms.

Interviews with ADOC #105 and DOC #101 confirmed that resident #030's identified supplementary therapy was not provided as specified in the resident's plan of care.

The scope of this non-compliance is isolated as it relates to one resident. The severity of harm and risk of harm to residents arising from the non-compliance resulted in actual harm/risk. The home's Compliance History Report reveals a

voluntary plan of correction (VPC) was issued in February 2016 in report 2016_298557_0003. As a result of the scope, severity and the licensee's previous compliance history, a compliance order is warranted. (652)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 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 13th day of December, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ariel Jones

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