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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 7, 2018	2018_616542_0010	025030-17, 025417-17, 025420-17, 026105-17, 026681-17, 002528-18, 003192-18, 004433-18, 007540-18	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Maple View of Sault Ste. Marie
650 Northern Avenue SAULT STE. MARIE ON P6B 4J3

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

JENNIFER LAURICELLA (542), LISA MOORE (613), LOVIRIZA CALUZA (687)

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): April 30, 2018 - May 11, 2018.

A Follow Up Inspection #2018_616542_0009 and a Critical Incident Inspection #2018_616542_0011 were completed concurrently with this Complaint Inspection. PLEASE NOTE: A Written Notification and Compliance Order (CO) related to

LTCHA, 2007, c. 8, s. 6 (7) and O. Reg. 79/10, s. 33 (1) were identified in this inspection and have been issued in Inspection Report #2018_616542_0009 dated, June 7, 2018, which was conducted concurrently with this inspection.

The following logs were inspected;

One intake related to, plan of care and medication management,
One intake, related to, staffing, complaints, nutrition and hydration, prevention of abuse and dining,
One intake, related to, plan of care, resident rights, staffing, prevention of abuse, nail care and supplies,
One intake, related to, plan of care, continence and bowel management, reporting and complaints,
One intake, related to, falls prevention,
One intake, related to, prevention of abuse,
One intake, related to, authorization for admission,
One intake, related to, responsive behaviours, prevention of abuse, bathing, plan of care and falls prevention and
One intake, related to, prevention of abuse, altercations, nursing and personal care services and plan of care.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care, the Assistant Director of Care, Registered Nurses (RN), Registered Practical Nurses (RPNs), Dietary Manager, Office Manager, Physicians, Personal Support Services Manager, Director of First Impressions, Physiotherapists, maintenance staff, Personal Support Workers (PSWs), Scheduling staff, Social Service Worker, Family members and residents.

The Inspectors also conducted a tour of the resident care areas, reviewed resident care records, home investigation notes, home policies, relevant personnel files and observed resident rooms, resident common areas, and the delivery of resident care and services, including resident-staff interactions.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **4 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 residents were protected from abuse by anyone and failed to ensure that residents were not neglected by the licensee or staff.

A complaint was submitted to the Director, outlining that the home failed to ensure that resident #005's continence care needs were met. The complainant indicated resident #005 was admitted to the hospital due to their care needs not being met.

Ontario Regulation (O. Reg.) 79/10, s. 5 defined neglect as, "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."

Inspector #542 completed a review of resident #005's current care plan located on PointClickCare (PCC). The care plan indicated that resident #005 had numerous health conditions along with being diagnosed with a specific condition. Inspector #542 further reviewed the care plan which indicated the resident was at a risk of a specific condition.

See WN #1 for s. 6 (7) in the Follow Up Inspection Report # 2018_616542_0009 where the licensee failed to ensure that the care set out in the plan of care was provided to resident #005 as specified in the plan.

A review of resident #005's paper health care record was completed by Inspector #542. Within the record, Inspector #542 located a document titled, "Medical Directives" that were signed, as being approved by the Medical Director. Under the condition, designation it was documented to provide the resident with a specific intervention if they had not had a specific condition in three days. The Physician was to be notified by staff if the resident experienced a specific condition.

Inspector #542 reviewed the "Daily Care Flow Sheets" from October,2017, which were used for the direct care staff to document the care of the residents. The document indicated that the resident experienced a specific condition for an extended duration.

Inspector #542 reviewed the Electronic Medication Administration Record (EMAR) from October 2017 for resident #005. The record concluded that resident #005 did not receive any further intervention to assist with a specific condition as required. .

Inspector #542 reviewed the progress notes for resident #005 during a 12 day period in October, 2017. The progress notes concluded that there was no documentation to indicate that resident #005 was provided with further intervention for a specific number of days. It was documented that on on a specific day, resident #005 was transferred to the

hospital due a change in their health status. Furthermore, there was no documentation to indicate that an assessment was completed or that the physician was contacted during an extended period of time when the resident was experiencing a specific condition.

See WN #3 in this report, where the licensee failed to ensure that drugs were administered to resident #005 in accordance with the directions for use specified by the prescriber for further details.

Inspector #542 interviewed the Acting Director of Care #110 who verified that there was no further documentation to indicate that an assessment was completed for resident #005 leading up to the hospital admission.

Inspector #542 interviewed RPN #113 who indicated that when a resident was provided with a medication as per the Medical Directives, then it would be documented on the EMAR and the progress notes. RPN #113 reviewed the EMAR and the progress notes, from October, 2017 with this Inspector and verified that there was no documentation to indicate that resident #005 received the individualized Medical Directives to alleviate their medical condition.

Inspector #542 reviewed the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect Program" last updated, April 2017. The policy defined neglect as, the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. [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. 6. Plan of care

Specifically failed to comply with the following:

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. 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.

A complaint was submitted to the Director indicating that the home failed to listen to the family members request to assess resident #008 for a specific infection. The complainant indicated that they had concerns that resident #008 had an infections and asked the home to obtain a specimen.

Inspector #687 reviewed the home's policy titled "Care Planning" last updated on April 2017, which indicated that the resident's plan of care which included the care plan was to serve as a communication tool which;

- Enhanced the provision of individualized care and
- Assisted in provision of continuity of care as all team members were aware of the individualized plan.

Inspector #687 completed a health care record review for resident #008. The progress notes included documentation on a specific day in Janaury, 2018, by RPN #115 which indicated that the family was concerned regarding resident #008's health status. RPN

#115 further documented that resident #008 was agitated and felt clammy to touch and had an increased temperature and that the family was concerned that resident #008 had an infection and documented that it was on the physician's board for assessment.

Inspector #687 completed a review of the resident #008's home area, agenda. The Inspector identified that on three specific shifts, the night shift staff were to collect a specimen for resident #008.

In a record review of the home's Complaint Investigation Log form, dated a specific day in February, 2018, Inspector #687 identified that on a previous day in February, RN #114 communicated the specimen request of resident #008's family to the physician. The complaint log documentation further indicated that the RN spoke to the physician and was given the impression that it would be addressed that day or the next day.

Inspector #687 completed an interview with RN #114. They indicated that one of their roles were to check the Medical Provider Communication Sheets and transcribe the concerns that were not addressed by the physician or nurse practitioner from the previous unit rounds to the New Medical Provider Communication Sheets for the next physician/nurse practitioner unit rounds. The RN further stated that they did not have a chance to review them as the home was so busy. The RN also verified that they had a 24 hour physician on-call coverage and stated that if it were an urgent concern, they would call the on-call physician.

In a record review of resident's #008's progress notes dated, for a day in Febrary, RPN #140 documented that they were not successful at obtaining the specific specimen from resident #008.

In an interview conducted by Inspector #687 with RPN #140, the RPN stated that on that same day, they attempted to obtain the specimen from resident #008 but they were unsuccessful. The RPN further stated that they had reported this failure to obtain the specimen from resident #008 to the next shift and could comment what happened on succeeding days as they only worked part time in the home.

On May 2, 2018, Inspector #687 conducted a phone interview with a family member of resident #008. They indicated that their main concern was that the staff in the home did not listen to the family about their concern with resident #008's health status. On a number of occasions they asked the staff to obtain the specimen as they felt that resident #008 had an infection. The family member indicated that it took the home over two

weeks to obtain the specimen.

In an interview with RN#114, the RN stated that if a family member requested a specimen be collected for their loved one, the request would be noted in the physician/nurse practitioner book. And once a specimen order was received, then they would obtain the specimen, it would be written in the day planner for the night shift RPN to collect the specimen.

In an interview with physician #141, the physician stated that if the family was "forceful" about their specimen request, then the physician would write an order to appease the family members but should always keep in mind that it should be in the best interest of the resident.

In an interview with the Acting DOC #110, they stated that for family members of a resident requesting for a specimen collection due to concerns of a potential infection, the home tended to do what the family request and accommodate them. The DOC stated that if it was a family member that requested a specimen for a resident, the registered staff would normally wait for the physician's order prior to collecting the specimen. The specimen should be obtained in a timely manner; they specified that it should be done the next day or the following day. They further specified that if it was during the weekend, the staff should obtain it immediately on the next business day. The Acting DOC#110 acknowledged that two weeks for a specimen collection was too long and it was not acceptable. [s. 6. (4) (b)]

2. The licensee has failed to ensure that the SDM, if any, and the designate of the resident/SDM had been provided the opportunity to participate in the development and implementation of the plan of care.

A complaint was submitted to the Director, in relation to resident #009. Resident #009's family member indicated that the home did not notify them when resident #009's health status changed on a specific day in 2017, and later passed away at the hospital, three days later.

Inspector #687 completed a health care record review for resident #009. The progress notes, identified that RPN #128 observed resident #009 start coughing and had a large emesis and looked very pale. A PSW assisted resident #009 to their room for personal care and RPN #128 followed behind the resident. The resident had an increased temperature reading and was provided with medication for the elevated temperature and

they were transferred to bed. At 2020 hours, RPN #128 went back to resident #009's room to monitor the resident and observed that the resident had another emesis and diarrhea. The RPN provided a different medication to manage resident #009's nausea and vomiting. The resident's temperature remained elevated.

In a record review of the resident's progress notes on the same day that resident #009 fell ill, at 2033 hours, it was identified that RN #143 went to assess the resident. The resident's temperature was elevated and they had another emesis. The resident denied malaise and had audible digestive gurgling.

In a record review of the resident's progress notes dated that same day, at 2143 hours, it was identified that the Nurse Practitioner had seen resident #009 and the plan was to continue with the treatments for fever and nausea as per the home's medical directive.

In a record review of the home's policy titled "Case Definitions" last updated on September 2017, the Inspector identified that under the Gastrointestinal Tract Infection, the following criteria must be met:

- Two (2) episodes of vomiting in a 24-hour period

The Case Definition policy further indicated that if any case definitions were met, it was required to be documented in the progress notes, updated in the care plan and also required notification of illness to the Power of Attorney (POA) and/or Substitute Decision Maker (SDM) and/or family.

In an interview with resident #009's family member, they indicated that their loved one had since passed away. Their main concern was that they were not made aware when resident #009's health condition deteriorated, on that specific day. The family member stated that their spouse received a phone call around 1330 hours the next day, from RN #144 stating that the resident's condition had improved and that staff were reviewing products for wound care.

The RPN #128 indicated that they tried to manage the resident's symptoms first and did not call the family of resident #009 on the day the resident fell ill. The RPN further stated that knowing what they know now, they would have called the family for any change of the resident's condition.

In an interview with RPN #122, the RPN stated that they were under the impression that

resident #009's condition was stable as the NP assessed the resident on the day they fell ill. The RPN stated that, two days later, they were on their way to monitor the resident's vital signs on night shift and found that the resident's health status had changed. The RPN stated that they called the resident's family member to inform them of the resident's condition that required transfer to the hospital. The RPN further stated that the resident's family member was upset as they were not made aware that the resident's health condition had deteriorated.

In an interview with RN #114, the RN stated that when a resident exhibited any enteric symptoms such as vomiting, the registered staff would obtain vital signs, assess the overall appearance of the resident and depending on the severity of the resident's condition, it would be an immediate notification to the family members.

In an interview with the Acting DOC #110, they stated that for any change of the resident's condition, the registered staff were to inform the family either by phone or verbal information of the resident's changing condition. The DOC further stated that their expectation was that their registered staff would notify the family and that the notification via phone or verbal communication with the family would be within the registered staffs' scheduled shift. [s. 6. (5)]

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 resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A complaint was submitted to the Director, outlining concerns that the licensee had failed to provide medications necessary for resident #005.

A review of resident #005's paper health care record was completed by Inspector #542. Within the record, Inspector #542 located a document titled, "Medical Directives" that was signed as being approved by the Medical Director. Under the condition heading, it was documented to provide the resident with a medication if they had a specific health condition. Furthermore, under certain circumstances staff were to notify the physician.

Inspector #542 reviewed the "Daily Care Flow Sheets" from October, which were used for the direct care staff to document the care of the residents. The document described that the resident was experiencing a specific condition for an extended duration.

Inspector #542 reviewed the Electronic Medication Administration Record (EMAR) from October 2017 for resident #005. The record concluded that resident #005 did not receive any further medication. Resident #005's individualized Medical Directives were not provided to the resident.

Inspector #542 interviewed RPN #113 who indicated that when a resident was provided with a medication as per the Medical Directives then it would be documented on the EMAR and the progress notes. RPN #113 reviewed the EMAR and the progress notes, from October, 2017 with this Inspector and verified that there was no documentation to indicate that resident #005 received the individualized Medical Directives. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the licensee withheld approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out, (a) the ground or grounds on which the licensee was withholding approval; (b) a detailed explanation of the supporting facts, as they related both to the home and to the applicant's condition and requirements for care; (c) an explanation of how the supporting facts justified the decision to withhold approval; and (d) contact information for the Director.

A complaint was received by the Director, identifying that the licensee denied an applicant admission to the home.

During an interview with Social Service Worker #104, they provided the application forms that the home had received in October, 2017, and verified that the applicant had been denied admission. SSW #104 stated that they had began their employment with the home as of April 30, 2018, but would attempt to locate a refusal letter. At a later time on the same date, SSW #104 was unable to locate a written notice and stated that they would check with the Acting Director of Care.

A review of the home's policy titled, "Screening for Admission" last revised April 2017, revealed that the Administrator or delegate would notify the relevant authority and the applicant via a letter, advising that the application could not be accepted because the residents' care needs exceed what the home can safely provide if the care and treatment needs of an applicant could not be safely met within the home.

During an interview with the Acting Director of Care, they stated that it was the home's practice to provide the applicants with a written notice of acceptance and refusal and when a resident was denied admission, a letter would be sent to the applicant and the Director to inform why the admission was denied. The Acting Director of Care confirmed that the home had not submitted a letter to the applicant.

The application for admission process was not followed whereby the licensee was to provide a written notice to the applicant, the Director and the appropriate placement coordinator setting out the reasons for withholding approval for admission. [s. 44. (9)]

Issued on this 8th day of June, 2018

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) :	JENNIFER LAURICELLA (542), LISA MOORE (613), LOVIRIZA CALUZA (687)
Inspection No. / No de l'inspection :	2018_616542_0010
Log No. / No de registre :	025030-17, 025417-17, 025420-17, 026105-17, 026681-17, 002528-18, 003192-18, 004433-18, 007540-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 7, 2018
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Maple View of Sault Ste. Marie 650 Northern Avenue, SAULT STE. MARIE, ON, P6B-4J3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Carly Brown

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s.19 (1) of the Act.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents were protected from abuse by anyone and failed to ensure that residents were not neglected by the licensee or staff.

A complaint was submitted to the Director, outlining that the home failed to ensure that resident #005's continence care needs were met. The complainant indicated resident #005 was admitted to the hospital due to their care needs not being met.

Ontario Regulation (O. Reg.) 79/10, s. 5 defined neglect as, "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."

Inspector #542 completed a review of resident #005's current care plan located on PointClickCare (PCC). The care plan indicated that resident #005 had numerous health conditions along with being diagnosed with a specific condition. Inspector #542 further reviewed the care plan which indicated the resident was at a risk of a specific condition.

See WN #1 for s. 6 (7) in the Follow Up Inspection Report # 2018_616542_0009 where the licensee failed to ensure that the care set out in the plan of care was provided to resident #005 as specified in the plan.

A review of resident #005's paper health care record was completed by Inspector #542. Within the record, Inspector #542 located a document titled, "Medical Directives" that were signed, as being approved by the Medical Director. Under the condition, designation it was documented to provide the resident with a specific intervention if they had not had a specific condition in three days. The Physician was to be notified by staff if the resident experienced a specific condition.

Inspector #542 reviewed the "Daily Care Flow Sheets" from October,2017, which were used for the direct care staff to document the care of the residents. The document indicated that the resident experienced a specific condition for an extended duration.

Inspector #542 reviewed the Electronic Medication Administration Record (EMAR) from October 2017 for resident #005. The record concluded that resident #005 did not receive any further intervention to assist with a specific condition as required. .

Inspector #542 reviewed the progress notes for resident #005 during a 12 day period in October, 2017. The progress notes concluded that there was no documentation to indicate that resident #005 was provided with further intervention for a specific number of days. It was documented that on on a specific day, resident #005 was transferred to the hospital due a change in their health status. Furthermore, there was no documentation to indicate that an assessment was completed or that the physician was contacted during an extended period of time when the resident was experiencing a specific condition.

See WN #3 in this report, where the licensee failed to ensure that drugs were administered to resident #005 in accordance with the directions for use specified by the prescriber for further details.

Inspector #542 interviewed the Acting Director of Care #110 who verified that there was no further documentation to indicate that an assessment was completed for resident #005 leading up to the hospital admission.

Inspector #542 interviewed RPN #113 who indicated that when a resident was provided with a medication as per the Medical Directives, then it would be documented on the EMAR and the progress notes. RPN #113 reviewed the

EMAR and the progress notes, from October, 2017 with this Inspector and verified that there was no documentation to indicate that resident #005 received the individualized Medical Directives to alleviate their medical condition.

Inspector #542 reviewed the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect Program" last updated, April 2017. The policy defined neglect as, the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. [s. 19. (1)]

The decision it issue this compliance order was based on the scope which had been identified as isolated, the severity which indicated minimal harm or a potential for actual harm, and the compliance history which despite previous non-compliance having been issued with two Compliance Orders issued between August 14, 2016 and February 27, 2017, in report #2016_395613_0007 and #2016_562620_0030; non-compliance continued with this section of the legislation. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 06, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 7th day of June, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Jennifer Lauricella

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