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 # / No de registre	Type of Inspection / Genre d'inspection
Apr 30, 2018	2018_644507_0008	023330-17, 006204-18	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

STELLA NG (507)

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): March 12 - 15, 19 - 22, 27 - 28, and April 3, 2018. The off-site inspection was conducted on March 6 - 9, and April 4, 2018.

The following intakes were completed in this complaint inspection:
Log #023330-17 was related to residents' Bill of Rights, plan of care, medication administration and licensee to forward written complaints to the Director; and
Log #006204-18 was related to alleged staff to resident abuse and whistle-blowing protection.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), substitute decision-maker (SDM), family member and visitor.

During the course of the inspection, the inspector conducted observation of provision of care, record review of resident and home records, staff schedule and relevant home policies.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

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 resident #001 was not neglected by staff.

Review of intake #023330-17 revealed that resident #001’s substitution decision-maker (SDM) lodged a complaint to the Ministry of Health and Long Term Care (MOHLTC) in regards to the management of resident #001’s health conditions in two identified periods which the resident was sent to the hospital (second and third hospitalizations).

Review of resident #001’s medicine discharge summary from hospital on an identified date, revealed that resident #001 was hospitalized (first hospitalization) for eight days. Home staff were asked to look out for symptoms of a specific health condition.

Review of resident #001’s discharge summary from hospital on an identified date revealed that the resident was treated for the specific health condition during the second hospitalization.

A) Record review of resident #001’s progress notes and resident unit planner for an identified unit for seven days of the first identified period, revealed the following documentation in relation to the follow up on a specific laboratory test result:
On an identified date, the SDM took the specimen to an identified laboratory.
Six days later, SDM enquired about the result of the specimen and provided telephone number of the laboratory where the specimen was sent to staff for follow up. Laboratory result indicated the resident was having a specific health condition. The home physician was informed and medications were prescribed for the resident.

In interviews, staff #101, #102, and #104 stated that when a resident’s specimen was sent to the laboratory for above mentioned specified test, the result normally returned in three to four days. Staff would communicate to others by documenting in the resident’s progress notes and the 24 hours communication report book, so that the oncoming staff would follow up on tracking the results. Staff #104 further stated that if the result did not return in four days, staff would call the laboratory for results. In an interview, staff #107 stated that it was every staff member’s responsibilities to follow up on laboratory results. Staff #107 also stated that when a specimen was sent for the specific test, there was a possibility of suspected specific health condition. Staff should communicate to the oncoming staff every shift in regards to the resident’s condition.

Record review of the progress notes of resident #001 and the resident unit planner for the identified unit for the same period failed to reveal that the home tracked the results of the specimen which was sent on the identified date. Six days after the specimen was sent, staff #107 obtained the laboratory result which indicted resident #001’s specimen was tested positive for the specific health condition. The home physician was informed

and medications were prescribed for the resident.

In an interview, staff #113 verified that the result for the specific test would take about three days to return, a delay may occur on weekends. It was the nurses' responsibilities to follow up on tracking and notifying doctor of the result, and document in the progress notes. Staff #113 stated that resident #001's specimen was sent on the identified date, and staff could have followed up on the laboratory result sooner than six days.

B) Record review of resident #001's progress notes, medication administration record (MAR) and resident unit planner for the identified unit for a period of six days prior to the second hospitalization, revealed the following documentation in relation to the resident's specific health condition and interventions:
First day - Resident complained of pain, and pain medication was given, and medications were given later of the day for a specific health condition, and SDM was informed of the resident's condition.
Second day – Medications were given three times for the specific health condition, and the resident was assessed by the doctor in the morning.
Third day – Medications were given twice for the specific health condition, and SDM was informed of the resident's condition.
Fifth day – The resident was sent to the hospital for assessment.

In interviews, staff #101 #105, #107 and #111 stated that the medical directives for resident #001 was that the resident could have the above mentioned medications for the specific health condition, and staff should call the physician if the health condition was not resolved after 24 hours. Staff #101 and #105 stated that they were aware that resident #001 had a history of the specific health condition and were also aware of the instructions from the hospital after the first hospitalization. Staff #105 also stated that resident #001's SDM was very involved in the resident's care and visited regularly. When the SDM visited, staff always updated and discussed the resident's condition with the SDM, and the SDM made intervention decisions and participated in medication administration to the resident. Staff #105 further stated that if the doctor was notified of the resident's condition and/or SDM declined to send the resident to the hospital, staff would document in the progress notes.

Record review of resident #001's progress notes for the above mentioned days, failed to reveal further assessment and/or investigation was taken in regards to resident #001's ongoing specific health condition. The home did not take the action that was recommended by the hospital after the first hospitalization. The failure of the home to

assess the resident as required is a pattern of inaction as defined by the Act.

In interview, staff #113 stated that resident #001 was assessed by the doctor and started medications on the first day of the identified period, it would take a couple days for the medications to work. Staff #113 further stated that resident #001 had multiple factors that would take longer to respond to medications, and staff had been monitoring the resident.

Record review of resident #001’s progress notes for 10 days prior to the third hospitalization revealed the following documentation in relation to the resident’s specific health condition and interventions:
First day - Medications were given for pain, and SDM was informed.
Fourth day – Medications were given for pain.
Sixth day – Medications were given twice for the specific health condition.
Seventh day – medications given twice for the specific health condition. The doctor assessed the resident and prescribed medications to the resident, SDM was informed of the condition.
Eighth day – Medications were given twice for the specific health condition.
Ninth day – Medications were given once for the specific health condition.
Tenth day – medications were given once for the specific health condition, and the resident was sent to the hospital for assessment later of the day.

In interviews, staff #104 and #103 stated that the medical directives for resident #001 was that the resident could have medications given for the specific health condition, and if the specific health condition was not resolved after 24 hours, staff should call the physician. Staff #104 stated that it was known that resident #001 had a history of the specific health condition and was aware of the instructions from the hospital after the first hospitalization. Staff #104 also stated that resident #001’s SDM was very involved in the resident’s care, SDM visited almost daily and called for updates frequently. SDM would tell the staff what to do or what not to do for the resident. When the SDM was visiting or calling, staff would update the SDM of the resident’s status, and sometimes the SDM would give direction to the staff, such as sending or not sending the resident to hospital.

Record review of resident #001’s progress notes from the seventh to ninth day from the above mentioned period failed to reveal further assessment and/or investigation was taken in regards to resident #001’s ongoing specific health condition. The home did not take the action that was recommended by the hospital ater the first hospitalization. The failure of the home to assess the resident as required is a pattern of inaction as defined by the Act.

In interview, staff #113 stated that resident #001 was assessed by the doctor and started medications on the seventh day of the above mentioned period, it would take a couple days for the medications to work. Staff #113 further stated that resident #001 had multiple factors that would take longer to respond to medications, and staff had been monitoring the resident. [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. (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 resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Review of intake #023330-17 revealed that resident #001's identified medication was increased without providing the SDM an opportunity to participate fully in the decision making.

Record review of resident #001's medication administration records (MAR), physician's order forms and progress notes for a one year period revealed that resident #001 was prescribed the identified medication since admission on an identified date. During resident #001's stay in the home, the dosage and/or frequency of the identified medication had been changed from time to time due to the resident's status or request

from the SDM at the time. Record review of resident #001's progress notes also revealed that the SDM was not afforded an opportunity to consent to the changes in this medication for some of the times that the identified medication order was changed. Further review of resident #001's health record, physician's order and progress notes revealed that the resident's SDM was not provided an opportunity to participate fully in the decision making on four occasions when resident #001's identified medication dosage and/or frequency were changed. Record review of the MAR for resident #001 revealed the identified medication was given as per changed dosages on those four occasions.

In interviews, staff #101, #102, #104, #106, and #111 stated according to the home's policy, consent from SDM was not required for the administration of the identified medication. Staff also stated that not all the families would like to be notified of any small changes. For those families who would like to be informed, staff would call and notify the families prior to any treatment. Staff #101 stated that doctor would be notified if family did not agree with the changes of medication, and doctors usually did whatever family requested. Staff #104 and #105 stated that resident #001's SDM was very involved in the resident's care by either visiting almost daily or calling frequently to enquire about the resident's status. Staff #105 further stated that resident #001's SDM participated in medication administration to the resident when visiting, and staff would inform the SDM of everything related to the resident when resident #001's SDM called.

In an interview, staff # 113 verified that when a resident's medication was changed, the home's protocol was to notify families if the resident's status has changed. Written consent would not be required for the identified medication. Staff #113 stated that families signed the consent for treatment form when the resident was admitted, and that would cover providing consent for medication changes, except specific medications, which required written consent. Staff #113 further stated that staff did not obtain consent from resident #001's SDM or notify the SDM when the resident's identified medication dosage was changed based on the home's protocol.

Resident #001's SDM was not given an opportunity to participate fully in the development and implementation of the resident's plan of care, in particular when the resident's identified medication dosage was changed on four identified occasions. [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. 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, inducing assessments, reassessments, interventions and the resident’s responses to interventions were documented.

A) On an identified date, the MOHLTC received a complaint from resident #001’s SDM in regards to a specified assessment was not being followed after resident #001 experienced a fall on an identified date.

Record review of resident #001’s progress notes and incident report on an identified date, revealed that resident #001 was found lying on the floor on the identified date. The resident complained of pain during assessment. Resident #001 was sent to the hospital for further assessment and returned to the home a few hours later, as confirmed during interviews with staff #109 and #112. Record review of the Emergency Department Discharge Summary on the identified date revealed that resident #001 was assessed at the emergency department. Further review of the incident report revealed that resident

#001 experienced an unwitnessed fall, and a specified assessment was initiated, as confirmed during interview with staff #113.

Review of the home's policy for the specified assessment revised November 2010 directed the staff to conduct the specified assessment after a resident has fallen. There are several components to the assessment that are to be completed .

Review of resident #001's heath record failed to reveal the specific assessment initiated on the identified date, and continued on the next day. Review of resident #001's progress notes on the identified date, after the resident was found lying on the floor, and the progress notes dated the next day, failed to reveal the assessment of resident #001's specified components of the assessment, as confirmed during interviews with staff #109 and #112.

In an interview, staff #113 verified that specific assessment should be initiated and continued when a resident experienced an unwitnessed fall. Staff #113 stated that the specific assessment should have been initiated prior to sending resident #001 to the hospital on the identified date, and continued when the resident returned from the hospital as per the home's policy.

B) On an identified date, the MOHLTC received a complaint from resident #001's SDM in regards to resident #001's altered skin integrity was not assessed in two identified occasions.

Record review of resident #001's progress notes for two identified months revealed two entries related to the resident's altered skin integrity:
- On an identified date, altered skin integrity from the previous fall was noted, and the resident denied pain on the location of the altered skin integrity, and
- On another identified date, altered skin integrity was noted.

Review of the home's policy titled, "Incident Report – Reporting, Documentation and Assessment of Incidents" (policy number:717-HC-NS) indicated the following:
- altered skin integrity (explained/ unexplained) is one of the occurrence that required a completion of an incident report by the registered nursing staff,
- the registered nursing staff completes a thorough physical assessment of the resident (s) involved to determine the extent of injuries,
- if an incident involves a fall, the registered nursing staff must include in their assessment and documentation in certain areas, including altered skin integrity, and

- nursing staff must complete documentation for 48 hours after an incident has occurred should continue follow-up and treatment as required.

Record review of resident #001’s progress notes of the above two identified entries failed to reveal the specified components of the assessment of the altered skin integrity discovered, as confirmed by interview with staff #113. Further review of resident #001’s progress notes failed to reveal any documentation related to the resident’s identified altered skin integrity for 48 hours after the initial documentation, as confirmed by interview with staff #113.

Record review of resident #001’s health record failed to reveal the following:
- Incident reports related to the above mentioned altered skin integrity observed on the above mentioned identified dates.
- Thorough physical assessments of the resident upon the discovery of the altered skin integrity on both identified dates, and
- Documentation for 48 hours after the discovery of the altered skin integrity on both identified dates.

Staff documented the discovery of altered skin integrity on both identified dates were not available for interviews.

In an interview, staff #113 verified that staff are required to complete an incident form when discovered a resident had altered skin integrity. Staff #113 further stated that the resident had a fall one day prior to the above mentioned first identified date, and the altered skin integrity was discovered the next day, and an incident report would not be necessary when the altered skin integrity was discovered. Staff #113 also stated that when resident #001’s altered skin integrity was discovered on both identified dates, staff should have documented the altered skin integrity in more details, the assessments conducted and the interventions provided.

The home’s specific assessment and incident report – reporting, documentation and assessment of incidents policies were not implemented when resident #001 had an unwitnessed fall on an identified date, and upon the discovery of the altered skin integrity on the resident on two identified dates. [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, inducing assessments, reassessments, interventions and the resident's responses to interventions were documented, to be implemented voluntarily.

WN #4: 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 any written complaints concerning the care of a resident or the operation of the home were immediately forwarded to the Director.

Review of intake #023330-17 revealed that the complainant had submitted a written complaint to the home on an identified date, and the home did not forward the written complaint to the Director.

Record review of an email sent to the home on the above mentioned identified date from resident #001's SDM revealed that there were concerns in regards to the care resident #001 received from an identified staff.

In an interview, staff # 114 stated that the above mentioned email was not forwarded to the Director as required as the home did not consider the identified email was a written complaint. [s. 22. (1)]

Issued on this 2nd day of May, 2018

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

Original report signed by the inspector.

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	STELLA NG (507)
Inspection No. / No de l'inspection :	2018_644507_0008
Log No. / No de registre :	023330-17, 006204-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 30, 2018
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:

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.

Specifically the licensee must:
a) Implement an on-going auditing process to ensure that the laboratory results for any resident's specific specimen sent out for the specific test are tracked and followed up on.
b) Ensure any resident with a history of the specific health condition and has another specific health condition, is assessed and appropriate interventions for care are implemented.
c) Maintain a written record of audits conducted of tracking and following up in regards to residents' specific specimen send for the specific test. The written record must include the date, the resident's name, staff member's name, the name of the person completing the audit and the outcome of the audit.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #001 was not neglected by staff.

Review of intake #023330-17 revealed that resident #001's substitution decision-maker (SDM) lodged a complaint to the Ministry of Health and Long Term Care (MOHLTC) in regards to the management of resident #001's health conditions in two identified periods which the resident was sent to the hospital (second and third hospitalizations).

Review of resident #001's medicine discharge summary from hospital on an identified date, revealed that resident #001 was hospitalized (first hospitalization) for eight days. Home staff were asked to look out for symptoms

of a specific health condition.

Review of resident #001's discharge summary from hospital on an identified date revealed that the resident was treated for the specific health condition during the second hospitalization.

A) Record review of resident #001's progress notes and resident unit planner for an identified unit for seven days of the first identified period, revealed the following documentation in relation to the follow up on a specific laboratory test result:
On an identified date, the SDM took the specimen to an identified laboratory. Six days later, SDM enquired about the result of the specimen and provided telephone number of the laboratory where the specimen was sent to staff for follow up. Laboratory result indicated the resident was having a specific health condition. The home physician was informed and medications were prescribed for the resident.

In interviews, staff #101, #102, and #104 stated that when a resident's specimen was sent to the laboratory for above mentioned specified test, the result normally returned in three to four days. Staff would communicate to others by documenting in the resident's progress notes and the 24 hours communication report book, so that the oncoming staff would follow up on tracking the results. Staff #104 further stated that if the result did not return in four days, staff would call the laboratory for results. In an interview, staff #107 stated that it was every staff member's responsibilities to follow up on laboratory results. Staff #107 also stated that when a specimen was sent for the specific test, there was a possibility of suspected specific health condition. Staff should communicate to the oncoming staff every shift in regards to the resident's condition.

Record review of the progress notes of resident #001 and the resident unit planner for the identified unit for the same period failed to reveal that the home tracked the results of the specimen which was sent on the identified date. Six days after the specimen was sent, staff #107 obtained the laboratory result which indicted resident #001's specimen was tested positive for the specific health condition. The home physician was informed and medications were prescribed for the resident.

In an interview, staff #113 verified that the result for the specific test would take about three days to return, a delay may occur on weekends. It was the nurses'

responsibilities to follow up on tracking and notifying doctor of the result, and document in the progress notes. Staff #113 stated that resident #001's specimen was sent on the identified date, and staff could have followed up on the laboratory result sooner than six days.

B) Record review of resident #001's progress notes, medication administration record (MAR) and resident unit planner for the identified unit for a period of six days prior to the second hospitalization, revealed the following documentation in relation to the resident's specific health condition and interventions:
First day - Resident complained of pain, and pain medication was given, and medications were given later of the day for a specific health condition, and SDM was informed of the resident's condition.
Second day – Medications were given three times for the specific health condition, and the resident was assessed by the doctor in the morning.
Third day – Medications were given twice for the specific health condition, and SDM was informed of the resident's condition.
Fifth day – The resident was sent to the hospital for assessment.

In interviews, staff #101 #105, #107 and #111 stated that the medical directives for resident #001 was that the resident could have the above mentioned medications for the specific health condition, and staff should call the physician if the health condition was not resolved after 24 hours. Staff #101 and #105 stated that they were aware that resident #001 had a history of the specific health condition and were also aware of the instructions from the hospital after the first hospitalization. Staff #105 also stated that resident #001's SDM was very involved in the resident's care and visited regularly. When the SDM visited, staff always updated and discussed the resident's condition with the SDM, and the SDM made intervention decisions and participated in medication administration to the resident. Staff #105 further stated that if the doctor was notified of the resident's condition and/or SDM declined to send the resident to the hospital, staff would document in the progress notes.

Record review of resident #001's progress notes for the above mentioned days, failed to reveal further assessment and/or investigation was taken in regards to resident #001's ongoing specific health condition. The home did not take the action that was recommended by the hospital after the first hospitalization. The failure of the home to assess the resident as required is a pattern of inaction as defined by the Act.

In interview, staff #113 stated that resident #001 was assessed by the doctor and started medications on the first day of the identified period, it would take a couple days for the medications to work. Staff #113 further stated that resident #001 had multiple factors that would take longer to respond to medications, and staff had been monitoring the resident.

Record review of resident #001's progress notes for 10 days prior to the third hospitalization revealed the following documentation in relation to the resident's specific health condition and interventions:
First day - Medications were given for pain, and SDM was informed.
Fourth day – Medications were given for pain.
Sixth day – Medications were given twice for the specific health condition.
Seventh day – medications given twice for the specific health condition. The doctor assessed the resident and prescribed medications to the resident, SDM was informed of the condition.
Eighth day – Medications were given twice for the specific health condition.
Ninth day – Medications were given once for the specific health condition.
Tenth day – medications were given once for the specific health condition, and the resident was sent to the hospital for assessment later of the day.

In interviews, staff #104 and #103 stated that the medical directives for resident #001 was that the resident could have medications given for the specific health condition, and if the specific health condition was not resolved after 24 hours, staff should call the physician. Staff #104 stated that it was known that resident #001 had a history of the specific health condition and was aware of the instructions from the hospital after the first hospitalization. Staff #104 also stated that resident #001's SDM was very involved in the resident's care, SDM visited almost daily and called for updates frequently. SDM would tell the staff what to do or what not to do for the resident. When the SDM was visiting or calling, staff would update the SDM of the resident's status, and sometimes the SDM would give direction to the staff, such as sending or not sending the resident to hospital.

Record review of resident #001's progress notes from the seventh to ninth day from the above mentioned period failed to reveal further assessment and/or investigation was taken in regards to resident #001's ongoing specific health condition. The home did not take the action that was recommended by the hospital ater the first hospitalization. The failure of the home to assess the resident as required is a pattern of inaction as defined by the Act.

In interview, staff #113 stated that resident #001 was assessed by the doctor and started medications on the seventh day of the above mentioned period, it would take a couple days for the medications to work. Staff #113 further stated that resident #001 had multiple factors that would take longer to respond to medications, and staff had been monitoring the resident.

The severity of this issue was determined to be a level 3 as there was actual harm/risk to resident #001. The scope of the issue was a 1 as it related to one resident. The home had a level 4 history of on-going non-compliance with this section of the Act that included:
- Compliance Order (CO) issued April 10, 2017 (2017_302600_0003)

(507)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 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   30th   day of April, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : STELLA NG

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