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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 11, 2018	2018_624196_0023	009365-18, 010400-18, 015531-18, 017166-18, 019294-18, 019689-18, 020397-18	Complaint

Licensee/Titulaire de permis

St. Joseph's Care Group
35 North Algoma Street P.O. Box 3251 THUNDER BAY ON P7B 5G7

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

Hogarth Riverview Manor
300 Lillie Street THUNDER BAY ON P7C 4Y7

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

LAUREN TENHUNEN (196), DEBBIE WARPULA (577), KATHERINE BARCA (625), 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): August 27 to 31, and September 5 and 6, 2018.

The following intakes were inspected upon during this Complaint inspection:

- One related to nursing and personal support services, and the plan of care;
- One related to nursing and personal support services, and the provision of care;
- One related to nursing and personal support services, the plan of care, pain and falls management; and
- Five related to nursing and personal support services, the plan of care, alleged staff to resident neglect, and provision of care.

Critical Incident System (CIS) inspection #2018_624196_0024 and Follow Up inspection #2018_624196_0022 were conducted concurrently with this Complaint inspection.

Non-compliance pursuant to the LTCHA, 2007, S. O. 2007, c. 8, s. 6 (7), identified from the concurrent Complaint inspection will be issued in the Follow Up inspection report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Clinical Managers (CMs), Physiotherapist (PT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Infection Prevention and Control (IPAC) Facilitator, Resident Assessment Instrument (RAI) Coordinators, Staff Educator, Staffing Coordinator, Dietary Aides, Resident Home Workers (RHW), family members and residents.

The Inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, home's internal investigation notes and complaints, staff education records, as well as reviewed numerous licensee policies, procedure and programs.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Sufficient Staffing

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

- **7 WN(s)**
- **6 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 not neglected by the licensee or staff.

A CIS report was received by the Director on a date in 2018, which alleged that resident #001 had been neglected. The report indicated that the resident had not received their scheduled medication; they had not been assessed for a period of time and had a significant change in condition where they were transferred for further treatment.

According to the Long-Term Care Homes Act, 2007 O. Reg 79/10, s.5, neglect is defined 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.

A record review of the physician orders for resident #001 indicated that the resident was prescribed a type of medication, on a particular date, for a specified period of time.

A review of the progress notes, indicated that resident #001 received the first dose of their prescribed medication at a specific time on a specific date. The progress notes dated the following day, indicated that RPN #147 had neglected to give the scheduled medication at a specific time, and had not documented an assessment over a specific period of time; and further, RPN #147 was informed by a PSW that the resident appeared to be in an altered condition. Later that same day, the resident was transferred for further treatment.

A review of the home’s policy titled "Zero Tolerance of Resident Abuse and Neglect Program - RC-02-01-01" revised April 2017, indicated that Extendicare was committed to providing a safe and secure environment in which all residents were treated with dignity and respect and protected from all forms of abuse or neglect at all times.

During an interview with RPN #147, they reported to Inspector #577 that they had neglected to administer the scheduled medication to resident #001, as the medication had not been delivered from pharmacy but they could have obtained the medication from another area and called pharmacy. They further reported that they had not assessed resident #001 for a specified period of time, where the residents condition had changed and they required further treatment.

During an interview with CM #130 and the DOC, they both reported to Inspector #577 that resident #001 had been neglected, as the resident had not received their medication; RPN #147 had not re-assessed resident #001’s condition for a specified period of time and had neglected to assess the resident when they were approached by PSW #148

concerning the resident's altered condition. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure to immediately forward any written complaints that have been received concerning the care of a resident or the operation of the home to the Director.

A specified number of complaints were received by the Director in 2018, which alleged multiple areas of concern related to the care of resident #001.

A CIS report was received by the Director on a date in 2018, concerning alleged neglect of resident #001, related to their care.

A review of the letter submitted by the complainants indicated that they had submitted numerous documented concerns in writing to the Family Council Assistant on a date in 2018.

During an interview with the complainants, they reported to Inspector #577 that on a date in 2018, they had submitted many written concerns related to the care of resident #001 to the Family Council Assistant.

A review of the home's policy titled "Complaints Management Program - LTC 5-70" revised December 2017, indicated that all written complaints were to be reported to the Ministry of Health and Long-Term Care, Centralized Intake Assessment and Triage Team (CIATT).

During an interview with CM #130, they reported to Inspector #577 that they had received written concerns related to the care of resident #001 on a date in 2018, which had been forwarded through the Family Council. They further confirmed that they had not immediately forwarded the care concerns to the Director. [s. 22. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures any written complaints that are received concerning the care of a resident or the operation of the home are immediately forwarded to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A complaint was submitted to the Director regarding the application of resident #021's positioning device. The complaint alleged that the resident had an incident and injury and subsequently required a positioning device which had been incorrectly applied by the home's staff, on multiple occasions in a two month time period, in 2017.

Inspector #625 reviewed resident #021's health care record which included progress notes that identified complaints about the resident's positioning device being incorrectly applied on multiple dates in a two month period in 2017. The notes identified that the positioning device had been applied upside down on one date in 2017, when an RN had to remove and properly reapply the positioning device.

During an interview with Inspector #625, the complainant stated that the home had been totally unprepared for what they had to do with resident #021's positioning device and that they had observed resident #021's positioning device applied incorrectly on numerous occasions. The complainant stated they had brought the incorrect application of the positioning device to the attention of the Physiotherapist who had fixed the positioning device.

During an interview with Physiotherapist (PT) #149, they stated that the resident had an incident and sustained an injury requiring a positioning device. The PT indicated that staff were not really aware of how to apply the positioning device and that a former Physiotherapy Assistant had informed them that the positioning device had not been applied correctly on two occasions, including on one occasions where they had observed it applied upside down and reported it to a Registered Nurse (RN) who fixed it.

During an interview with RN #150, they stated that they knew there had been an issue with resident #021's positioning device and that some people had not put the positioning

device on properly. The RN stated that some RNs may not have had training on the application of the positioning device.

During an interview with RN #124, they stated that the staff had not been provided proper training on the application of resident #021's positioning device and they had advocated for more training on the application of the positioning device. The RN stated they had been shown how to apply the positioning device once, and that instructions on how to apply it had not been consistent. The RN identified that they had observed the resident's positioning device applied incorrectly on approximately five occasions and had observed it applied upside down and without required padding on it. [s. 36.]

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 that ensures staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every verbal or written complaint made to the licensee or a staff member concerning the care of a resident was investigated and resolved where possible, and a response that complies with paragraph 3 was provided within 10 business days of the receipt of the complaint.

A specified number of complaints were received by the Director in 2018, which alleged multiple areas of concern related to the care of resident #001.

A CIS report was received by the Director on a date in 2018, concerning alleged neglect of resident #001 related to their care.

A review of the letter submitted by the complainants, indicated that they had submitted numerous documented concerns in writing to the Family Council Assistant on a date in 2018.

During an interview with the complainants, they reported to Inspector #577 that on a date in 2018, they had submitted many written concerns related to the care of resident #001 to the Family Council Assistant.

A review of the home’s policy titled "Complaints Management Program - LTC 5-70" revised December 2017, indicated that a complaint would be investigated and resolved where possible, and a response was provided to the complainant within ten business days of the receipt of the complaint.

During an interview with CM #130, they reported to Inspector #577 that they had received written concerns related to the care of resident #001 on a date in 2018, which had been forwarded through the Family Council. Additionally, they could not confirm that every concern brought forward by the complainants through the Family Council was discussed at the family and nursing care plan meeting on a specific date in 2018. [s. 101. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures every verbal or written complaint made to the licensee or a staff member concerning the care of a resident is investigated and resolved where possible, and a response that complies with paragraph 3 is provided within 10 business days of the receipt of the complaint, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. An injury in respect of which a person was taken to hospital.

On a specific date in 2018, a written complaint was sent to the licensee outlining care concerns and that resident #009 had an incident on a date in 2018. The licensee subsequently submitted the written complaint to the Director.

Inspector #196 conducted a review of resident #009's health care records. The progress notes indicated that on a specific date in 2018, the resident had an incident and was sent to the hospital. The resident returned to the home later that same day and the hospital discharge record identified an injury, treatment and plan.

During an interview with the DOC, they reported that a CIS report was not submitted to the Director as the resident had come back on the same day and there had been no change to the residents' health status.

During a further interview with the DOC, they confirmed to the Inspector that the resident did have a significant change to their health status as a result of the incident and a CIS had not been submitted to the Director and should have been. [s. 107. (3) 4.]

2. The licensee who was required to inform the Director of an incident under subsection (1), (3) or (3.1), has failed to ensure that within 10 days of becoming aware of the incident, or sooner if required by the Director, a report was made in writing to the Director setting out the following with respect to the incident: Actions taken in response to the incident, including, the outcome or current status of the individual or individuals who were involved in the incident.

A CIS report was received by the Director on a date in 2018, concerning alleged neglect of resident #001 related to their care.

During a review of the amended CIS report, Inspector #577 noted that on a specific date in 2018, the Triage Inspector had requested information be provided including, specific information regarding the allegation of neglect, outcome of the investigation and the long term actions planned to prevent recurrence.

During a further review of the amended CIS report, Inspector #577 found that the amendments made had not included a description of neglect. Documented immediate actions indicated that a meeting occurred on a date in 2018, and the investigation was pending. The documented outcome indicated that resident #001 had not suffered any ill effects from the concerns.

During an interview with the DOC, they confirmed with Inspector #577 that they had documented the amendments for the CIS report on a date in 2018, which did not include a description of neglect, a description of the immediate actions nor a documented outcome. [s. 107. (4) 3. v.]

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 that ensures the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): An injury in respect of which a person was taken to hospital and of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: Actions taken in response to the incident, including, the outcome or current status of the individual or individuals who were involved in the incident, to be implemented voluntarily.

WN #6: 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).

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

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 CIS report was received by the Director on a date in 2018, which alleged that resident #001 had been neglected. The report indicated that the resident had not received their scheduled medication; they had not been assessed for a period of time and had a significant change in condition which required further treatment.

Ontario Regulation 79/10 describes a medication incident as a preventable event associated with the prescribing, ordering, dispensing, storing, labeling, administering or distributing of a drug, or the transcribing of a prescription, and includes:
(a) an act of omission or commission, whether or not it results in harm, injury or death to a resident; or
(b) a near miss event where an incident does not reach a resident but had it done so, harm, injury or death could have resulted.

A review of the progress notes indicated that resident #001 had received the first dose of their scheduled medication at a specific time on a specific date in 2018. The following day, the resident did not receive their scheduled medication at a certain time of the day. Consequently, the resident had a significant change in condition and required further care.

A review of the home's policy from the pharmacy service provider titled "Medication Administration Errors" revised March 2017, defined an omission error as failure to administer an ordered dose by the time the next dose was due.

During an interview with RPN #147 they reported to Inspector #577 that they neglected to administer the scheduled medication to resident #001 as the medication had not been delivered from pharmacy but could have obtained the medication from another area and called pharmacy.

During an interview with CM #130 and the DOC, they both reported to Inspector #577 that resident #001 had not received their scheduled medication and consequently had a significant change in condition and were transferred for further treatment later that day. [s. 131. (2)]

2. The licensee has failed to ensure that no resident administered a drug to himself or herself unless the administration had been approved by the prescriber in consultation with the resident.

During the inspection, Inspector #577 observed RPN #144 to have placed medication on resident #001's tabletop, instructed the resident to take their medication and walked away from the resident. Inspector #577 observed the resident take their medication over 20 minutes.

A record review of the pharmacy service providers' policy titled "Administration of Medications – General Guidelines" revised January 2017, indicated that medications were administered in accordance with written orders of the physician or other authorized prescriber.

During an interview with RPN #144, they reported to Inspector #577 that they had administered a specific number of medications mixed in fluid. They further confirmed that they did not confirm that the resident had finished taking their medication.

During an interview with RPN #139, they reported that staff were required to administer medication to resident #001.

During an interview with RPN #141, they reported that staff were required to administer resident #001's medication.

During an interview with the DOC, they confirmed that registered staff must observe the residents taking their medication. [s. 131. (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 that ensures drugs are administered to residents in accordance with the directions for use specified by the prescriber and no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's written record was kept up to date at all times.

A CIS report received by the Director on a date in 2018, identified that resident #001 had a change in condition and were transferred to an acute care facility on a date in 2018, and returned to the home an approximate number of days later.

During a record review of resident #001's fluid intake records for this specific month in 2018, Inspector #577 found the following:

- on one day, their total fluid intake was a specific amount and a specific number of servings
- on another day, their total fluid intake was a specific amount and a specific number of servings
- the following day, their total fluid intake was a specific amount and a specific number of servings
- on another day, their total fluid intake was a specific amount

A record review of resident #001's progress notes indicated that they were transferred to an acute care facility on a date in 2018, and returned to the home an approximate number of days later.

During an interview with CM #130 and the DOC, they reported that they did not know why staff had documented fluid intakes for resident #001, during the time that they were admitted to an acute care facility. [s. 231. (b)]

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 that ensures the resident's written record is kept up to date at all times, to be implemented voluntarily.

Issued on this 19th day of October, 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) :	LAUREN TENHUNEN (196), DEBBIE WARPULA (577), KATHERINE BARCA (625), LOVIRIZA CALUZA (687)
Inspection No. / No de l'inspection :	2018_624196_0023
Log No. / No de registre :	009365-18, 010400-18, 015531-18, 017166-18, 019294-18, 019689-18, 020397-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 11, 2018
Licensee / Titulaire de permis :	St. Joseph's Care Group 35 North Algoma Street, P.O. Box 3251, THUNDER BAY, ON, P7B-5G7
LTC Home / Foyer de SLD :	Hogarth Riverview Manor 300 Lillie Street, THUNDER BAY, ON, P7C-4Y7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lina Johnson

To St. Joseph's Care Group, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee must:

a) Ensure resident #001 and all residents, are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.
b) Provide education to RPN #147, regarding the provision of ordered medications, the need to assess residents when their conditions indicate, and the home's policy on zero tolerance of abuse and neglect of residents.
c) Maintain documentation of the education provided to RPN #147, the dates of the training, the content of the training, and the name of the person responsible for providing the education.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

A CIS report was received by the Director on a date in 2018, which alleged that resident #001 had been neglected. The report indicated that the resident had not received their scheduled medication; they had not been assessed for a period of time and had a significant change in condition where they were transferred for further treatment.

According to the Long-Term Care Homes Act, 2007 O. Reg 79/10, s.5, neglect is defined 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.

A record review of the physician orders for resident #001 indicated that the resident was prescribed a type of medication, on a particular date, for a specified period of time.

A review of the progress notes, indicated that resident #001 received the first dose of their prescribed medication at a specific time on a specific date. The progress notes dated the following day, indicated that RPN #147 had neglected to give the scheduled medication at a specific time, and had not documented an assessment over a specific period of time; and further, RPN #147 was informed by a PSW that the resident appeared to be in an altered condition. Later that same day, the resident was transferred for further treatment.

A review of the home's policy titled "Zero Tolerance of Resident Abuse and Neglect Program - RC-02-01-01" revised April 2017, indicated that Extendicare was committed to providing a safe and secure environment in which all residents were treated with dignity and respect and protected from all forms of abuse or neglect at all times.

During an interview with RPN #147, they reported to Inspector #577 that they had neglected to administer the scheduled medication to resident #001, as the medication had not been delivered from pharmacy but they could have obtained the medication from another area and called pharmacy. They further reported that they had not assessed resident #001 for a specified period of time, where the residents condition had changed and they required further treatment.

During an interview with CM #130 and the DOC, they both reported to Inspector #577 that resident #001 had been neglected, as the resident had not received their medication; RPN #147 had not re-assessed resident #001's condition for a specified period of time and had neglected to assess the resident when they were approached by PSW #148 concerning the resident's altered condition. [s. 19. (1)]

The decision to issue this Compliance Order (CO) was based on the severity of actual harm to one resident and the scope was isolated. The home has a history of non-compliance in this area of the legislation as follows:
- a CO was issued from a Critical Incident System (CIS) inspection #2017_509617_0017, on October 11, 2017,

- a Voluntary Plan of Correction (VPC) from a CIS inspection #2016_391603_0022, on November 7, 2016,
- a CO was issued from a Resident Quality Inspection (RQI) #2016_435621_0012, on October 11, 2016. (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 16, 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 11th day of October, 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 : Lauren Tenhunen

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