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 sions de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 25, 2016	2016_226192_0013	003566-15	Complaint

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

Midland Gardens Care Community
130 MIDLAND AVENUE SCARBOROUGH ON M1N 4B2

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

DEBORA SAVILLE (192), ALICIA MARLATT (590), ALISON FALKINGHAM (518), SHERRI COOK (633)

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 4, 5, 6, 7, 8, 11, 12, 13, 14, 2016.

Complaint Inspection related to the following intakes were completed during this inspection:
log 003566-15 related to IL-37541-TO and IL-40336-TO
log 004394-15 related to IL-37563-TO
log 004576-15 related to IL-37967-TO and IL-38121-TO
log 006128-15 related to IL-38147-TO and IL-38561-TO

log 008755-15 related to IL-38310-TO
log 011016-15 related to IL-38773-TO
log 020679-15 related to IL-39810-TO
log 021738-15 related to IL-39873-TO
log 030295-15 related to IL-32539-TO
log 008795-15 related to IL-38495-TO
log 030295-15 related to IL-32539-TO
log 027119-15 related to IL-40846-TO
log 028491-15 related to IL-41013-TO
log 030295-15 related to IL-32539-TO
log 034430-15 related to IL-41923-TO
log 035202-15 related to IL-41565-TO
log 036083-15 related to IL-42177-TO and IL-42193-TO
log 002450-14 related to IL-33689-TO

This Complaint Inspection was completed concurrently with Critical Incident Inspection 2016_226192_0014 and Follow-up Inspection 012760-15.

Non-compliance identified during this Complaint Inspection in relation to LTCHA 2007, S.O. 2007, chapter 8, s. 76 (7)1 was issued on the report for Critical Incident Inspection 2016_226192_0014.

Findings of non-compliance identified during Critical Incident Inspection 2016_226192_0014 related to LTCHA 2007, S.O. 2007, chapter 8, s.20(1), s. 24(1) and O.Reg 79/10, s. 8(1)b were issued on this Complaint Inspection Report.

**During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the Executive Director,
Interim Director of Nursing, Associate Directors of Nursing, Director of Food Services, Food
Services Supervisors, Environmental Services Manager, Office Manager, Registered Dietitian,
Physiotherapist, Scheduling Clerk, Director of Resident Programs, Housekeeping and
Laundry Supervisor, Registered Nurses, Registered Practical Nurses, Personal Support
Workers, Dietary Aides, Housekeepers, Pest Control Provider and residents.**

**Inspectors toured the home areas, observed the housekeeping and maintenance of the home,
reviewed schedules, medical records, incident reports, maintenance logs, policy and
procedure and program evaluations.**

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **5 VPC(s)**
- **4 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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

Observation on April 6, 2016, at 1030 hours identified that the base of sit to stand lifts on the fourth floor were heavily soiled with dirt and debris. The blood pressure cuff positioned at the nursing station on the fifth floor was observed to have a heavily soiled base, with brown staining noted. Laundry carts on the fifth floor, north corridor were observed to have a soiled frame with splashes of a red substance on the white frame.

Observation on April 6, 2016, at 1215 hours identified a large number of dead insects between the screen and the glass of the window, located near the entrance at the north stairwell.

The fall mat between beds three and four in room 215 was observed to be heavily soiled.

The shower room on the north corridor was observed and sit to stand lifts stored in the room were identified to have dirt and debris on the bases of the lifts. The shower stall was noted to have a brown substance on the right wall, a large accumulation of hair on the drain and black substance collected in the corners of the base of the shower. The toilet seat was observed to have a red substance on the front of the seat. The walls in the corridor of the home area were observed in various locations to have brown substance running down the walls. Two carts containing linen bags were observed to have a build up of dirt on the base.

Interview and observation with Environmental Service Manager #118 on April 6, 2016, at 1240 hours, confirmed that the shower and toilet in the shower room, on the second floor were not kept clean and sanitary and that linen carts were unclean. ESM #118 indicated that a contracted service (Cleana) was to clean the shower room daily and that laundry was to clean the laundry carts. ESM #118 confirmed that removing insects between the screen and window would be the responsibility of the contracted cleaning service. ESM #118 indicated that windows had been cleaned externally in May 2015, but had not been cleaned internally.

Interview and observation with Interim Director of Care (DOC) #102 confirmed that lifts in the second floor shower room were not kept clean and sanitary. DOC #102 confirmed that nursing staff were to clean the lifts following each transfer with a thorough cleaning

to be done weekly, however this was not being completed.

Interview with Housekeeper #122 on April 7, 2016, confirmed that the shower and toilet in the north shower room had not been cleaned on April 6, 2016. Housekeeper #122 confirmed that hair identified on the shower drain, the black substance on the shower floor, brown substance on the shower wall, and red substance on the toilet seat observed by inspectors 192 and 633 and management of the home on April 6, 2016, remained on April 7, 2016 and that walls in the home area were dirty and baseboards had cumulative grime.

The home's policy titled Equipment Cleaning - Resident Care and Medical Equipment, policy number VII-H-10.50, dated as revised January 2015, indicated that lifts were to be thoroughly cleaned and disinfected on a weekly schedule or more frequently if soiled and that all shared equipment must be cleaned and disinfected between resident uses. That all medical nursing equipment such as blood pressure machines, must be cleaned and disinfected between resident uses and on an as needed basis. To ensure medical equipment is free of visible soil. The DOC #102 confirmed that cleaning of equipment, as identified in the policy, was not being done in the home.

The licensee failed to ensure that the home and equipment were kept clean and sanitary. [s. 15. (2) (a)]

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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they were not being supervised by staff.

The door leading to the garbage bins and rear parking lot was equipped with a mag lock, however the door was observed to be propped open with cardboard on April 5, 2016, at 1030, 1108, and 1330 hours; April 7, 2016 at 1630 hours. No staff were in attendance at the time of observations made on April 5, 2016.

The main dining room was connected to the service corridor, where the door was observed to be propped open, by double doors that do not lock and do not have mag locks in place.

Interview with Environmental Services Manager #118, identified that staff do leave the door to the back parking lot propped open while taking garbage out of the home and at the time of deliveries and confirmed that doors between the service corridor and dining room were not secure.

Interview with Associate Director of Care #101 confirmed that residents may be in the main dining room unattended between 1630 hours and the time of meal service, especially with the elevator being down.

Observation on April 8, 2016, by inspector 633 identified that 20 residents were unattended in the main dining room between 1147 hours and 1201 hours.

The licensee failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff. [s. 9. (1) 2.]

2. The licensee has failed to ensure that all doors leading to non-residential areas were locked when they were not being supervised by staff.

On April 11, 2016, the door to the "Garbage Room" on the main floor was found to be accessible to Inspector #518 and could be accessed by the residents. There were chemicals and industrial equipment stored in this room. The inspector confirmed with a Recreation Program Manager #137 that this door was to be locked at all times and

locked the door.

On April 12, 2016, the door to the "Garbage Room" on the main floor was found to be accessible to Inspector #518 & #590. The Environmental Services Manager confirmed this door was to be locked at all times and locked the door. A sign had been posted that day instructing staff to keep the door locked at all times.

The licensee failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff. [s. 9. (1) 2.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 88. Pest control

Specifically failed to comply with the following:

s. 88. (2) The licensee shall ensure that immediate action is taken to deal with pests. O. Reg. 79/10, s. 88 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home took immediate action to deal with pests.

A pest control program was in place with weekly visits from Abell Pest Control.

Review of the documentation provided weekly by Abell Pest Control identified that the home had an ongoing problem with cockroaches in the kitchen and some resident areas.

An Abell Pest Control report dated March 18, 2015, indicated that roach activity was identified in the kitchen area at the half wall , oven area, on the 5th and 6th floors in resident rooms.

Review of random reports from Abell Pest Control provided throughout 2015, identified that issues continued with regard to roach activity and recommendations were made to the home, including removing food debris in half wall main kitchen, organic material in

dishwashing area and stagnant water in the kitchen.

An Abell Pest Control report dated March 11, 2016, indicated that roach activity continued in the kitchen and resident rooms on the third and fifth floors, with concerns related to sanitation, stagnant water and cleaning of the half wall in the kitchen.

The most recent Abell Pest Control report, dated April 5, 2016, identified roach activity in the half wall oven area with a further request to address sanitation issues, remove stagnant water, remove food in half wall oven area.

Observation on April 7, 2016, at 1700 hours identified insect activity under the double sinks, food including bananas and onions were stored in open boxes on the open shelf adjacent to the double sink. The half wall was observed with significant dirt and grim on items between the half wall. The floor in the dishwashing area remained wet with food debris on the floor and around the drain.

Interview with Director of Food Services #108 on April 8, 2016, denied roach activity in spite of the ongoing reports from the pest control company and confirmed that sanitation issues identified by the pest control company had not been addressed. Director of Food Services #108 confirmed that electronic reports are received from Abell Pest Control.

Interview with Route Manager, Abell Pest Control #155 on April 12, 2016, confirmed ongoing concerns related to roach activity and that recommendations had been made consistently to help the home address sanitation concerns that may be perpetuating the presence of roaches in the home.

The licensee failed to ensure that immediate action was taken to deal with pests. [s. 88. (2)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

**s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).**

Findings/Faits saillants :

1. The licensee has failed to ensure that staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The home's policy titled Surveillance and Process of Data Collection, policy number IX-E 10.10, dated as revised January 2015, indicated that registered staff would monitor all residents for signs and symptoms of infection and complete the Daily Surveillance Record.

Interview with the Assistance Director of Care #101 who was responsible for the Infection Prevention and Control program identified that Daily Surveillance Records were not available and records were not maintained by registered staff on the home areas.

The home was noted to be in Influenza Outbreak when inspectors entered the home on April 4, 2016.

The licensee failed to ensure staff monitor symptoms of infection in residents on every shift. [s. 229. (5) (a)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

The medical record and Critical Incident Report 2789-000032-15, indicated that on a specified date, while preparing resident #042 for transfer using a specified device, resident #042 sustained an injury that resulted in transfer to hospital.

Review of the investigation notes completed by the home at the time of the incident indicated that the staff member involved in the incident "roughly pulled" the resident, causing injury to the resident that resulted in transfer to hospital.

The licensee failed to ensure that resident #042 was treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity. [s. 3. (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 ensuring that every resident's right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity was respected, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The home's policy titled "Resident Leave of Absence/Transfer/Discharge", policy number VII-C-10.30, last revised January 2015, identified the following:

For casual or vacation leaves the Registered Practical Nurse (RPN)/Registered Nurse (RN) would provide the responsible person with care instructions including providing medications in pharmacy prepared packaging for the time period of the leave; complete the Medications Leave of Absence - Acceptance of Responsibility for Resident's During a Leave form; provide instructions related to the administration of medications; provide a printed Kardex outlining resident care needs, ensure the person responsible for taking the resident out of the home signed the LTC Resident Leave of Absence Form; and maintain contact with the resident in order to determine when the resident was returning to the home if not known.

Review of resident #006's progress notes revealed that they went on a Leave Of Absence (LOA) supervised by a family member on three specified occasions. The resident's medications were documented as being sent with the resident for the LOA.

Interview with RPN #105 identified that there was a process in place for the staff to follow when sending medications with a resident. The staff on the floor were to call pharmacy when they were informed that a resident would be taking an LOA and identify the date,

times and medications needed. The pharmacy would prepare the medication packages for the family and send to the floor. The registered staff on the floor were required to fill out an LOA form listing the medications given and to have the responsible person sign that they understood the instructions given. Two registered staff were required to sign the sheet. If providing an inhaler or cream instruction would be provided to the responsible person and they would be asked to return unused medications when the resident returned. The form was paper based and was kept in the residents chart.

Review of documentation for the LOA dates, when medications had been sent with the resident #006, with Associate Director of Care (ADOC) #101 confirmed the LOA medication responsibility forms were not completed for these dates and confirmed that registered staff should be using the appropriate form according to the home's policy. [s. 8. (1) (b)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The home's policy titled "Medication Management - Security & Storage", policy number VIII-F-10.20, dated as revised January 2015, identified that registered staff responsible for medication administration would follow the standards of practice for medication administration as documented by the College of Nurses of Ontario.

On a specified date, resident #008 required hospitalization for an acute illness and was transferred to the hospital. Prior to the resident leaving for the hospital registered staff administered their medication. The family was present at this time and witnessed the administration of medication by the nurse. At hospital, family intervened to prevent the resident from taken a second dose of the medication.

Interview with Registered Practical Nurse #126 confirmed that the resident did receive specified medication prior to leaving for the hospital and that the MAR had not been completed. The RPN was aware of the process for transferring a resident to hospital and confirmed that they should have sent the most current MAR to the hospital with the resident. The RPN indicated she had been directed to contact the hospital and notify them that the resident had receive the medications as above.

Interview with Interim Director of Care (DOC)#102 confirmed that the medications should have been signed on the MAR, when given and the most current MAR sent with the resident to the hospital. DOC #102 confirmed that the home did not follow their policy or

College of Nurses of Ontario standards of practice. [s. 8. (1) (b)]

3. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A complaint was received by the Ministry of Health and Long Term Care in 2015, alleging that residents were waiting for over two hours to receive their morning medications.

On April 12, 2016, on the sixth floor, north hallway, resident #081 was scheduled to receive medications at 0730 hours and 0800 hours. At 0920 hours Registered Practical Nurse (RPN) #135 was observed administering the medications for resident #081. RPN #135 stated that there were four residents awaiting medications for this medication pass.

On April 12, 2016, on the sixth floor, south hallway, resident #082 was due to receive oral medications scheduled for 0800 hours. At 0930 hours RPN #136 was observed to administer this medication for resident #082. RPN #136 stated that there were three residents awaiting medications for this medication pass.

On April 12, 2016, on the fifth floor, north hallway, resident #083 was scheduled to receive oral and subcutaneous medication scheduled for 0730 hours and 0800 hours. At 1000 hours RPN #121 was observed administering this medication to resident #083. RPN #121 stated that there were three residents awaiting medications for this medication pass.

Interviews with RPN #135, #136, #121 and Registered Nurse (RN) #130 revealed that they are educated annually on medication policies and procedures and are aware that the policy indicated that the standard practice was to follow the College of Nurses best practice guidelines which stated medication administration may occur within one hour of the scheduled or physician ordered time.

Associate Director of Care #101 confirmed the expectation was that all staff comply with the medication administration policy. [s. 8. (1) (b)]

4. The licensee has failed to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

A) The home's policy titled Internal Incident Reporting, policy number VII-G-10.70, dated as revised July 2015, indicated the Charge Person would complete the appropriate

incident report after a preliminary determination of the severity of the incident based on specified criteria.

On a specified date, resident #088 was the recipient of physical aggression that resulted in injury and transferred to hospital.

Record review identified that there was no internal incident report completed regarding this incident, no head to toe assessment completed after the injury and no head injury routine initiated after the injury.

Associate Director of Care (ADOC)#101 confirmed that an internal incident report had not been completed for this incident.

B)The home's policy Skin and Wound Care Management Protocol, policy number VII-G-10.80 dated as last revised July 2015, indicated Registered staff would conduct a skin assessment for a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, or skin tears.

ADOC #101 confirmed that a Head to Toe Skin Assessment was not completed following physical aggression that resulted in injury for resident #088.

C)The home's policy titled Head Injury Routine (HIR), policy number VII-G-10.40, dated as last revised January 2015, indicated that the Director of Care or designate would ensure Head Injury Routine(HIR) was initiated on any resident who had sustained or was suspected of having sustained a head injury and after any un-witnessed resident fall.

ADOC #101 confirmed that a HIR was not initiated or completed for resident #088 following physical aggression that resulted in injury.

ADOC #101 confirmed that it was her expectation that all of the home's policies were to be complied with by all staff. [s. 8. (1) (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 ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a resident-staff communication response system that could be easily seen, accessed, and used by residents, staff and visitors at all times.

During tour of the second floor of the home on April 6, 2016, at 1200 hours, it was observed that one or more call bell cords in rooms 205, 208, 211, 220 and 221 were laying on the floor and would not have been accessible by residents.

On April 6, 2016, at 1510 hours it was observed that call bells in room 205 remained on the floor and the privacy curtain was pulled in front of the call bell.

Interview with Personal Support Work #120 confirmed that the call bell would not be accessible to the resident. Two call bells in room 220 were observed on the floor and PSW #120 confirmed call bells are to be attached to the bed where residents would be able to reach them.

The licensee failed to ensure that the resident-staff communication response system could be easily seen, accessed and used by residents and staff of the home at all times. [s. 17. (1) (a)]

2. The licensee has failed to ensure that the resident-staff communication and response system was available at each bed, toilet, bath and shower location used by residents.

Tour of the second floor of the home on April 6, 2016, identified that in the bathroom in room 205, no call bell was available for the four resident's residing in the room.

Observation with Environmental Manager #118 on April 6, 2016 at 1230 hours confirmed that no call bell was available in the bathroom in room 205 and that it would have to be addressed. Where the call bell was to have been located was a box containing wires; no call bell or face plate covered the box.

The licensee failed to ensure that a resident-staff communication and response system was available in the bathroom of room 205.

It was observed that the call bell in the bathroom in room 205 was repaired on April 8, 2016, at 1013 hours. [s. 17. (1) (d)]

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 ensuring that the home had a resident-staff communication response system that could be easily seen, accessed, and used by residents, staff and visitors at all times and ensuring that the resident-staff communication and response system was available at each bed, toilet, bath and shower location used by residents, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff, that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

On a specified date in 2015, an incident occurred involving resident #043 that alleged a staff member had abused the resident. A critical incident was not completed and

submitted until 11 days later.

On a specified date in 2015, an incident occurred involving resident #042 that alleged a staff member had abused the resident. Management was made aware of the allegation. The after- hours number was called five days following the incident. The critical incident was completed forty-six days following the incident.

Interview with Interim Director of Care #102 confirmed that allegations of abuse have not been reported immediately as required and that the concern was ongoing. Incidents of alleged abuse may occur, staff are not communicating to management and it may be several days before the management team becomes aware of the incident through record review.

The licensee failed to ensure that suspected abuse that had occurred or may occur, was reported immediately to the Director. [s. 24. (1)]

2. The licensee has failed to ensure that the person who had reasonable grounds to suspect that misuse or misappropriation of a resident's money had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint in 2015, from a Substitute Decision Maker (SDM) for resident #006 indicating they suspected abuse of resident #006.

Review of resident #006's progress notes revealed the following:

On a specified date resident #006 reported potential abuse to staff at the home. The SDM indicated to the home's staff that they had suspected a specified person. The SDM further indicated that they had obtained information to confirm their suspicions and had contacted the Senior's Advocacy for Abuse.

On a subsequent specified date the SDM requested to be notified if resident #006 left the home.

Review of the "Prevention of Abuse & Neglect of a Resident" policy number VII-G-10.00 dated as last revised in January 2015, revealed in the Policy section that:

All employees, volunteers, agency staff, private duty caregivers, contracted service providers, resident, and families are required to immediately report any suspected or known incident of abuse or neglect to the Director of MOHLTC and the Executive Director/Administrator or designate in charge of the home.

Interview with Executive Director #100 confirmed that the Director was not notified of the allegation of abuse involving resident #006. [s. 24. (1)]

3. The licensee has failed to ensure that any person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

A) On a specified date in 2015, an incident of physical aggression occurred between resident #084 and #085 resulting in an injury.

An internal incident report was completed and the progress notes indicated that a nurse manager was notified however the critical incident report 2789-000089-15 was not submitted until three days following the incident.

B) On a specified date in 2016, an incident of physical aggression occurred between resident #084 and #086 resulting in injury. An internal incident report was completed and the progress notes indicated that the nurse manager was notified however the critical incident report 2789-000001-16 was not submitted until three days after the incident.

C) On a specified date in 2016, an incident of physical aggression occurred between resident #087 and #088 resulting in injuries to resident #088 who was transported to the hospital. An internal incident report was not completed and the progress notes indicated that a nurse manager was notified however the critical incident report 2789-000015-16 was not submitted until two days following the incident.

Associate Director of Care #101 confirmed the critical incident was not submitted nor was the after hours line contacted immediately following the incidents of resident to resident abuse.

The licensee failed to ensure that any person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by a licensee or staff that resulted in harm or risk of harm, immediately reported the suspicion and the information

upon which it is based to the Director. [s. 24. (1) 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 ensuring that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff, that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint in 2015, from a Substitute Decision Maker (SDM) for resident #006, indicating they suspected abuse of the resident.

Review of resident #006's progress notes revealed resident #006 had reported potential abuse, the SDM had been notified and confirmed that they suspected a specified person. The SDM indicated they had obtained further information to confirm their suspicions and had contacted the Senior's Advocacy for Abuse. The SDM subsequently requested they be notified if the resident was removed from the home.

Review of the "Prevention of Abuse & Neglect of a Resident" policy number XV-A-10.80 dated as last revised in January 2015, identified that the Executive Director/Administrator or designate at the time of notification by staff would immediately notify the Police of any alleged, suspected, or witnessed incident of abuse or neglect of a resident which may constitute a criminal offense.

Interview with Executive Director #100 confirmed that they did not notify the police of the above information.

The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence. [s. 98.]

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 ensuring that the appropriate police force is immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents had a screen.

During tour of the second floor on April 6, 2016, at 1200 hours it was observed that the window in the corridor of the North hall, near the stairs had no screen on the left side.

Observation with the Environmental Services Manager #118 on April 6, 2016, at 1230 hours confirmed that no screen was present on the window.

The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents had a screen. [s. 16.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

During observation on April 6, 2016, at 1210 hours and 1510 hours, it was noted that there were lingering offensive odours in a specified bathroom. The floor in the room appeared soiled.

Observation with the Environmental Services Manager (ESM) #118 on April 6, 2016 at 1230 hours confirmed that there was an odour in the bathroom and that they were not previously aware of an odour concern.

Observation on April 7, 2016 at 0955 identified the same offensive odour in the bathroom.

Interview with Housekeeper #122 confirmed that all bathrooms are to be cleaned daily.

The home's policy titled Odour Neutralizers-Housekeeping, policy number XII-G-10.30 dated as revised January 2015, indicated that the staff were to notify the ESM of areas requiring neutralizing agents.

The licensee failed to ensure that procedures were implemented for addressing incidents of lingering offensive odours. [s. 87. (2) (d)]

WN #12: 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 written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint.

The MOHLTC received a complaint that the home had not followed up with a family member regarding a complaint related to medication administration safety, made to management staff in 2015.

On a specified date in 2015, a near miss medication incident occurred involving resident #008.

Inspector had requested the notes completed by the home during their investigation into the allegations. The information provided was incomplete, and indicated the family had been called twice with no response. There were no dates or times to indicate when the phone calls had taken place.

Review of progress notes for resident #008 revealed no documentation of the family being contacted regarding their concerns.

Review of the home's policy titled "Resident/Family Complaints Procedure", policy number XV-A-10.10 dated as last revised in February 2016, indicated the General Manager or designate would provide a written response outlining what had been done to resolve the complaint, or that the complaint was believed to be unfounded and the reasons for the belief, to all written complaints within 10 days.

Interview with the Interim Director of Care (DOC) #102 confirmed that the Associate Director of Care (ADOC), at the time, had attempted to contact the family but had no success. She could not confirm the dates or times the attempts were made. She confirmed that the home was expected to provide a response to all concerns presented by families and residents within 10 days of the complaint being made. [s. 101. (1) 1.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 233. Retention of resident records

Specifically failed to comply with the following:

s. 233. (1) Every licensee of a long-term care home shall ensure that the record of every former resident of the home is retained by the licensee for at least 10 years after the resident is discharged from the home. O. Reg. 79/10, s. 233 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the record of every former resident of the home was retained by the licensee for at least 10 years after the resident was discharged from the home.

Resident #007 resided in the home over a specified period. Inspector was attempting to complete a complaint inspection and requested this resident's Medical Record from the Associate Director of Care (ADOC) #101 on April 5, 2016, at approximately 1000 hours. On April 6 at 1115 hours ADOC #101 notified the inspector that the medical record for resident #007 could not be located.

ADOC #101 confirmed that the home should still have access to this resident's paper documentation. [s. 233. (1)]

2. The licensee has failed to ensure that the record of every former resident of the home was retained by the licensee for at least 10 years after the resident was discharged from the home.

Resident #045 was admitted to the home on a specified date in 2015 and was discharged from the home on a specified date in 2015.

When asked to provide the medical record for resident #045, Assistant Director of Care #101 identified that the medical record for resident #045 was not available.

A financial record including the residents Power of Attorney was provided and the electronic records were available. The medical record containing consents, transfer records, consults, assessments, laboratory reports and physician orders could not be provided.

The licensee failed to ensure that the record of every former resident of the home was retained by the licensee for at least 10 years after the resident was discharged from the home. [s. 233. (1)]

Issued on this 27th day of April, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBORA SAVILLE (192), ALICIA MARLATT (590), ALISON FALKINGHAM (518), SHERRI COOK (633)
Inspection No. / No de l'inspection :	2016_226192_0013
Log No. / Registre no:	003566-15
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 25, 2016
Licensee / Titulaire de permis :	2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP 302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8
LTC Home / Foyer de SLD :	Midland Gardens Care Community 130 MIDLAND AVENUE, SCARBOROUGH, ON, M1N-4B2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sara Rooney

To 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The licensee shall ensure that equipment including but not limited to lifts, blood pressure cuffs, fall mats and laundry carts are kept clean and sanitary and that a process is developed to maintain and monitor the cleanliness of these items.

The licensee shall ensure that shower rooms on all home areas are kept clean and sanitary and that a process is developed to maintain and monitor the cleanliness of these areas.

The licensee shall ensure that walls and base boards are cleaned and maintained in a state of cleanliness.

The licensee shall ensure that windows of the home are audited, cleaned as appropriate and that a monitoring process is developed to ensure the cleanliness of the windows.

Grounds / Motifs :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

Observation on April 6, 2016, at 1030 hours identified that the base of sit to stand lifts on the fourth floor were heavily soiled with dirt and debris. The blood pressure cuff positioned at the nursing station on the fifth floor was observed to have a heavily soiled base, with brown staining noted. Laundry carts on the fifth

floor, north corridor were observed to have a soiled frame with splashes of a red substance on the white frame.

Observation on April 6, 2016, at 1215 hours identified a large number of dead insects between the screen and the glass of the window, located near the entrance at the north stairwell.

The fall mat between beds three and four in room 215 was observed to be heavily soiled.

The shower room on the north corridor was observed and sit to stand lifts stored in the room were identified to have dirt and debris on the bases of the lifts. The shower stall was noted to have a brown substance on the right wall, a large accumulation of hair on the drain and black substance collected in the corners of the base of the shower. The toilet seat was observed to have a red substance on the front of the seat. The walls in the corridor of the home area were observed in various locations to have brown substance running down the walls. Two carts containing linen bags were observed to have a build up of dirt on the base.

Interview and observation with Environmental Service Manager #118 on April 6, 2016, at 1240 hours, confirmed that the shower and toilet in the shower room, on the second floor were not kept clean and sanitary and that linen carts were unclean. ESM #118 indicated that a contracted service (Cleana) was to clean the shower room daily and that laundry was to clean the laundry carts. ESM #118 confirmed that removing insects between the screen and window would be the responsibility of the contracted cleaning service. ESM #118 indicated that windows had been cleaned externally in May 2015, but had not been cleaned internally.

Interview and observation with Interim Director of Care (DOC) #102 confirmed that lifts in the second floor shower room were not kept clean and sanitary. DOC #102 confirmed that nursing staff were to clean the lifts following each transfer with a thorough cleaning to be done weekly, however this was not being completed.

Interview with Housekeeper #122 on April 7, 2016, confirmed that the shower and toilet in the north shower room had not been cleaned on April 6, 2016. Housekeeper #122 confirmed that hair identified on the shower drain, the black

substance on the shower floor, brown substance on the shower wall, and red substance on the toilet seat observed by inspectors 192 and 633 and management of the home on April 6, 2016, remained on April 7, 2016 and that walls in the home area were dirty and baseboards had cumulative grime.

The home's policy titled Equipment Cleaning - Resident Care and Medical Equipment, policy number VII-H-10.50, dated as revised January 2015, indicated that lifts were to be thoroughly cleaned and disinfected on a weekly schedule or more frequently if soiled and that all shared equipment must be cleaned and disinfected between resident uses. That all medical nursing equipment such as blood pressure machines, must be cleaned and disinfected between resident uses and on an as needed basis. To ensure medical equipment is free of visible soil. The DOC #102 confirmed that cleaning of equipment, as identified in the policy, was not being done in the home.

The licensee failed to ensure that the home and equipment were kept clean and sanitary.

Previously issued as a Voluntary Plan of Corrective Action from inspection initiated November 30, 2015. There is a potential for actual harm related to the unclean state of the home and there is a pattern in that three of six home areas were identified to have concerns. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 29, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii.equipped with a door access control system that is kept on at all times, and
   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee shall ensure that doors leading to stairways and outside the home, or doors that residents do not have access to are kept closed and locked when not supervised by staff.

Grounds / Motifs :

1. The licensee has failed to ensure that all doors leading to non-residential areas were locked when they were not being supervised by staff.

On April 11, 2016, the door to the "Garbage Room" on the main floor was found to be accessible to Inspector #518 and could be accessed by the residents as well. There were chemicals and industrial equipment stored in this room. The inspector confirmed with a Recreation Program Manager #137 that this door is to be locked at all times and locked the door.
On April 12, 2016, the door to the "Garbage Room" on the main floor was found to be accessible to Inspector #518 & #590. The Environmental Services Manager confirmed this door was to be locked at all times and locked the door. A sign had been posted that day instructing staff to keep the door locked at all times.

This area of non-compliance was previously issued as a VPC during an inspection initiated on November 30, 2015. There is a potential for actual harm in that residents were observed unattended in the dining room; doors between the dining room and service corridor are not secure and their was a pattern of leaving doors in the service corridor propped open, including the external exit to the rear parking lot. (590)

2. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors were kept closed and locked when they were not being supervised by staff.

The door leading to the garbage bins and rear parking lot is equipped with a mag lock, however the door was observed to be propped open with cardboard on April 5, 2016, at 1030, 1108, and 1330 hours; April 7, 2016 at 1630 hours. No staff were in attendance at the time of observations made on April 5, 2016.

The main dining room is connected to the service corridor where the door was observed to be propped open, by double doors that do not lock and do not have mag locks in place.

Interview with Environmental Services Manager #118, identified that staff do leave the door propped open while taking garbage out of the home and at the

time of deliveries and confirmed that doors between the service corridor and dining room are not secure.

Interview with Assistance Director of Care #101 confirmed that residents may be in the main dining room unattended between 1630 hours and the time of meal service, especially with the elevator being down.

The licensee failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 88. (2) The licensee shall ensure that immediate action is taken to deal with pests. O. Reg. 79/10, s. 88 (2).

Order / Ordre :

The licensee shall ensure that immediate action is taken to deal with pests.

Grounds / Motifs :

1. The licensee has failed to ensure that the home took immediate action to deal with pests.

A pest control program is in place with weekly visits from Abell Pest Control.

Review of the documentation provided weekly by Abell Pest Control identified that the home has an ongoing problem with cockroaches in the kitchen.

A report dated March 18, 2015 indicated that roach activity was identified in the kitchen area at the half wall , oven area, on the 5th and 6th floors in resident rooms.

Review of random reports provided throughout 2015 identified that issues continued with regard to roach activity and recommendations were made to the home, including removing food debris in half wall main kitchen, organic material in dishwashing area and stagnant water in the kitchen.

A report dated March 11, 2016, indicated that roach activity continues in the kitchen and resident rooms on the third and fifth floors, with concerns related to sanitation, stagnant water and cleaning of the half wall in the kitchen.

The most recent report, dated April 5, 2016, identified roach activity in half wall oven area with a further request to address sanitation issues, remove stagnant water, remove food in half wall oven area.

Observation on April 7, 2016, at 1700 hours identified insect activity under the double sinks, food including bananas and onions were stored in a box on the open shelf adjacent to the double sink. The half wall was observed with significant dirt and grim on items between the half wall. The floor in the dishwashing area remained wet with food debris on the floor and around the drain.

Interview with Director of Food Services #108 on April 8, 2016, denied roach activity in spite of the ongoing reports from the pest control company and confirmed that sanitation issues identified by the pest control company had not been addressed. Director of Food Services #108 confirmed that electronic reports are received from the company.

The licensee failed to ensure that immediate action is taken to deal with pests.

There is no history for this area of non-compliance. There is potential for actual harm in that roaches were observed to be present in the kitchen. There is a pattern as the home has had evidence of roach activity identified weekly by the pest control provider and sanitation concerns have not been addressed for over a year. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2016

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Order / Ordre :

The licensee shall ensure that on every shift symptoms indicating the presence of infection in residents are monitored.

Grounds / Motifs :

1. The licensee has failed to ensure that staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The home's policy titled Surveillance and Process of Data Collection, policy number IX-E10.10, dated as revised January 2015, indicated that registered staff would monitor all residents for signs and symptoms of infection and complete the Daily Surveillance Record.

Interview with the Assistance Director of Care #101 who was responsible for the Infection Prevention and Control program identified that Daily Surveillance Records were not available and records were not maintained by registered staff on the home areas.

The licensee failed to ensure staff monitor symptoms of infection in residents on every shift.

This area of non-compliance was previously issued as a written notification during the inspection initiated November 30, 2016. There is potential for actual harm in that signs and symptoms of infection are not monitored daily by staff on the home areas and the problem is widespread. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 25th day of April, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DEBORA SAVILLE

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