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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 19, 2017	2017_420643_0006	001779-17	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

ADAM DICKEY (643)

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): February 23, 24, 28, March 1, 3, and 6, 2017.

The following critical incident intake was inspected concurrently with this complaint inspection: Log #030871-16 related to pain management.

During the course of the inspection, the inspector(s) spoke with the administrator, assistant directors of care (ADOC), physiotherapist (PT), environmental services manager (ESM), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSWs), and residents.

During the course of the inspection, the inspectors(s): observed resident rooms, observed staff to resident interactions and the provision of care; and reviewed resident health care records, staff training records, manufacturer's specifications, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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 O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial

interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Review of a complaint received by the Ministry of Health and Long-Term Care (MOHLTC) revealed that resident #001 had a fall on an identified date, which resulted in the resident experiencing pain.

Record review of resident #001's plan of care accessed on an identified date, revealed that he/she had pain. Interventions included pain assessment to be done weekly, and providing analgesia as ordered.

In an interview on an identified date, resident #001 stated that due to ongoing issues with identified care equipment, he/she was suffering from pain which was affecting sleep. Resident #001 stated that his/her pain level was nine out of ten and was terrible, but had an increase in his/her identified analgesic medication dosage as a result. Resident #001 further stated that he/she considered calling 911 if the pain was not managed better.

Record review of resident #001's health record revealed that he/she had been prescribed an identified analgesic medication daily for a four month period.

Record Review of progress note from an identified date, revealed resident #001 had requested to see the charge nurse on night shift, to request that the charge nurse document that the resident was in a lot of pain. An increase of pain medication was discussed with resident #001 in order to better manage his/her pain until it was possible to provide him/her with a replacement for the above mentioned identified care equipment.

On an identified date, the medication order was discontinued and a new order was prescribed for an identified analgesic medication twice daily as needed (PRN).

Progress note from an identified date, stated that resident #001 had been receiving pain medication twice during most night shifts. The entry further stated that resident #001 had been approaching registered staff on a daily basis to make sure registered staff had been documenting that he/she was in pain.

Progress note from an identified date, stated resident #001 had been expressing pain on an identified shift each day and requesting pain medication between identified hours. Progress notes revealed that resident #001 had received an identified analgesic medication on an identified shift daily between identified hours over an identified fifteen

day period.

On an identified date, the medication dosage was again changed; providing two tablets of identified analgesic medication daily at an identified time, and an additional tablet PRN at least four hours later.

Record review of the home's policy titled: Pain and Symptom Management policy #VII-G-30.10 last revised January 2015 revealed that registered staff are instructed to complete a pain assessment electronically quarterly for a resident with an MDS pain score of two or more, when receiving pain medication for greater than 24 hours and when report from resident, family, staff/volunteers that pain is present.

Review of resident #001's completed assessments in his/her electronic record revealed that the pain assessment was not completed since the initial admission pain assessment. No record of a subsequent pain assessment was found.

In an interview, ADOC #110 stated that it was the expectation of the home to complete the full pain assessment quarterly when MDS data shows that a resident is receiving an analgesic, as well as if the resident complained of pain over the observation period. ADOC #110 further stated that when resident #001's pain was not relieved by initial interventions a full pain assessment should have been completed.

In an interview, ADOC #116 who is the lead for the pain management program in the home, stated that the clinically appropriate assessment tool used to assess resident pain is the pain assessment for cognitively well which is completed electronically in the electronic health record. ADOC #116 further stated that a weekly pain assessment would also be initiated by registered staff for residents who had ongoing pain that needed to be monitored. ADOC #116 stated that as resident #001's pain was not relieved by the initial interventions in place the resident should be reassessed. In this case the licensee had failed to ensure that when resident #001's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The severity of this noncompliance is actual harm related to resident #001's pain not being managed by interventions in place. The scope was isolated to one resident. There is no previous compliance history related to r. 52. (2). Due to the severity of actual harm to resident #001 a compliance order is warranted. [s. 52. (2)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of a complaint received by the Ministry of Health and Long-Term Care (MOHLTC) revealed that resident #001 had a fall on an identified date, which resulted in the resident experiencing increased pain.

In an interview on an identified date, resident #001 stated that due to ongoing issues with identified care equipment, he/she was suffering from pain which was affecting sleep. Resident #001 stated that his/her pain level was nine out of ten and was terrible, but had an increase in his/her identified analgesic medication dosage as a result. Resident #001 further stated that he/she considered calling 911 if the pain was not managed better.

Record review of resident #001's plan of care accessed on an identified date, revealed that he/she had pain. Interventions included pain assessment to be done weekly, and providing analgesia as ordered.

Record review of resident #001's health record revealed that he/she had been prescribed an identified analgesic medication daily for a four month period.

On an identified date, the medication was discontinued and a new order was prescribed for the identified analgesic medication twice daily as needed (PRN).

On an identified date six days later, the medication dosage was again changed; providing

two tablets of identified analgesic medication daily at an identified time, and an additional tablet PRN at least four hours later.

Review of resident #001's completed assessments in his/her electronic health record revealed that a weekly pain assessment was completed on an identified date, and was not completed again until fifteen days later. Further review of completed assessments revealed the weekly assessment was not completed for an identified week in the previous month, and over another identified four-week period two months prior.

In an interview on an identified date, RPN #107 stated that pain assessments for resident #001 were completed on a weekly basis on an identified day by registered staff. He/she stated that it was not completed on the day prior to the interview but would complete it later that day.

In an interview, assistant director of care (ADOC) #110 stated that it was the expectation of the home to complete the weekly pain assessment each week on Monday for residents with ongoing pain management issues. He/she stated that the staff had missed the prior week's assessment and should have completed it each week on the above mentioned identified day. ADOC #110 acknowledged that the resident care plan was not followed related to the completion of the weekly pain assessments. In this case the licensee had failed to ensure that the care set out in the plan of care was provided as specified in the plan. [s. 6. (7)]

Issued on this 20th day of April, 2017

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) :	ADAM DICKEY (643)
Inspection No. / No de l'inspection :	2017_420643_0006
Log No. / Registre no:	001779-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 19, 2017
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) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Order / Ordre :

Upon receipt of this compliance order the licensee shall prepare and submit a plan to ensure that when resident #001, or other resident's pain is not relieved by initial interventions, that they are assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The plan will include at minimum the following elements:

- For each resident who is receiving analgesic medication daily to treat chronic pain, develop a system to assess if interventions in place are effective in relieving the resident's pain;
- For each resident whose pain is not relieved by current interventions complete a pain assessment to assess the resident's pain and refer to the physician to review the effectiveness of the resident's pain management interventions; and
- Education to all registered staff on the Pain and Symptom Management Policy to ensure that residents whose pain is not being relieved are reassessed using the clinically appropriate assessment tool.

Please submit the plan to Adam.Dickey@ontario.ca no later than May 3, 2017.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Review of a complaint received by the Ministry of Health and Long-Term Care (MOHLTC) revealed that resident #001 had a fall on an identified date, which

resulted in the resident experiencing pain.

Record review of resident #001's plan of care accessed on an identified date, revealed that he/she had pain. Interventions included pain assessment to be done weekly, and providing analgesia as ordered.

In an interview on an identified date, resident #001 stated that due to ongoing issues with identified care equipment, he/she was suffering from pain which was affecting sleep. Resident #001 stated that his/her pain level was nine out of ten and was terrible, but had an increase in his/her identified analgesic medication dosage as a result. Resident #001 further stated that he/she considered calling 911 if the pain was not managed better.

Record review of resident #001's health record revealed that he/she had been prescribed an identified analgesic medication daily for a four month period.

Record Review of progress note from an identified date, revealed resident #001 had requested to see the charge nurse on night shift, to request that the charge nurse document that the resident was in a lot of pain. An increase of pain medication was discussed with resident #001 in order to better manage his/her pain until it was possible to provide him/her with a replacement for the above mentioned identified care equipment.

On an identified date, the medication order was discontinued and a new order was prescribed for an identified analgesic medication twice daily as needed (PRN).

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The severity of this noncompliance is actual harm related to resident #001's pain not being managed by interventions in place. The scope was isolated to one resident. There is no previous compliance history related to r. 52. (2). Due to the severity of actual harm to resident #001 a compliance order is warranted. (643)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 15, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 19th day of April, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Adam Dickey

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