Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 24, 2017	2017_644507_0003	005039-17	Resident Quality Inspection

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

STELLA NG (507), ADAM DICKEY (643), ANGIE KING (644), FAYLYN KERR-STEWART (664), JOANNE ZAHUR (589), MATTHEW CHIU (565)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 7-10, 13 – 17, 20 – 24, 27 – 31, April 3 – 7 and 10 - 13, 2017.

The following critical incident reports were inspected concurrently with the Resident Quality Inspection (RQI):
#024208-16, #027194-16, #027619-16, #027992-16, #028397-16, #028446-16, #029539 -16, #030110-16, #030111-16, #030152-16, #030490-16, #033111-16, #033191-16,

#033610-16, #033806-16, #001761-17, #002467-17, #003509-17, #003854-17 and #007037-17 related to alleged staff to resident abuse/ neglect
#027626-16, #030355-16, #000048-17 and #004728-17 related to responsive behaviours,
#000737-16, #032993-16, #000208-17 and #007112-17 related to falls prevention and management,
#022791-16, #034041-16 and #003462-17 related to safe transferring,
#027616-16 and #004298-17 related to unknown injuries,
#005095-17 related to medication management.

The following complaints were inspected concurrently with the RQI:
#005598-17 related to continence care, skin and wound, menu planning, food production and recreation, and #006923-17 related to alleged retaliation.

The following compliance order follow-ups were inspected concurrently with the RQI: #002693-17 related to the cleanliness and condition of the home, furniture and equipment,
#002733-17 related to safe transferring and abuse prevention,
#002739-17 related to Residents' Council,
#002748-17 related to continence care and bowel management, responsive behaviours, staff education in abuse prevention and plan of care,
#027989-16 related to safe and secure home.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Acting Director of Care (A-DOC), Assistant Director of Care (ADOC), Nurse Manager (NM), Registered Nurses (RN), Registered Practical Nurses (RPN), Resident Assessment Instrument (RAI) Coordinator, Personal Support Workers (PSW), Physiotherapist (PT), Resident Relations Coordinator/ Social Worker (RCC/ SW), Director of Resident Programs (DRP), Activation Aide (AA), Registered Dietitian (RD), Director of Dietary Services (DDS), Dietary Services Supervisor (DSS), Dietary Aide (DA), Director of Environmental Services (DES), Laundry Supervisor (LS), Laundry Aide (LA), Housekeeping Supervisor (HS), Housekeeping Aide (HA), Maintenance Aide (MA), Clinical Care Partner (CCP), Pharmacist Consultant (PC), Residents' Council and Family Council Representatives, residents and family members.

During the course of the inspection, the inspector(s) conducted a tour of the home, observations of meal service, medication administration system, staff and resident

interactions and the provision of care, record review of health records, staff training records, meeting minutes for Residents' Council and Family Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **9 VPC(s)**
- **2 CO(s)**
- **2 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #009	2016_353589_0016	589
O.Reg 79/10 s. 230. (7)	CO #007	2016_353589_0016	589
O.Reg 79/10 s. 51. (2)	CO #004	2016_353589_0016	565
O.Reg 79/10 s. 54.	CO #005	2016_353589_0016	507
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #010	2016_353589_0016	589
LTCHA, 2007 S.O. 2007, c.8 s. 65.	CO #002	2016_353589_0016	644
O.Reg 79/10 s. 9. (1)	CO #001	2016_377502_0013	643
O.Reg 79/10 s. 99.	CO #006	2016_353589_0016	589

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 are kept clean and sanitary.

Two Compliance Orders were served under inspection report # 2016_226192_0013 and #2016_353589_0016 related to housekeeping and maintenance services in the home. Compliance Order #001 under inspection report #2016_353589_0016 directed the licensee to prepare, submit and implement a plan to achieve compliance in the areas of housekeeping and maintenance. The licensee was ordered to develop schedules to ensure that the home was kept clean and sanitary and in a state of good repair. The home was ordered to be in compliance by a specific date in March 2017.

a) On multiple occasions during the Resident Quality Inspection (RQI), the inspectors made several observations and interviews with staff related to the cleanliness of the home.

- a dark mold/mildew like substance at the base of the tiles in the shower stall in one of the bath rooms on an identified floor,
- tiles in the lower portion of the shower stall walls were dirty with a mold/mildew like substance in one of the bath rooms on another identified floor, and
- black areas of a mold/mildew like substance on the grout of the lower tiles in the shower stall in one of the bath rooms on two other identified floors.

In an interview, staff #223 stated that the expectation of the home is for the shower stalls to be wiped clean by the assigned housekeeping aide on each floor daily using orange cleaner. Staff #223 further stated that deep cleaning is completed once monthly in the bath rooms, including scrubbing of the shower stalls.

In an interview, staff #140 stated that housekeeping services in the home were provided by a contracted vendor which was responsible for developing procedures for cleaning in the home. Staff #140 stated that the expectation of the home is for shower stalls to be clean and free of mold/mildew. He/she further stated that these areas had not been cleaned up to the expectations of the facility. Staff #140 confirmed that these areas of the home were not kept clean and sanitary.

b) The resident library was observed for cleanliness as part of follow-up inspection of CO #001 under inspection report #2016_353589_0016 as the window areas of the library

had been found to be in an unclean state during the RQI.

Observations by the inspector on an identified date in the resident library located on the ground floor of the home revealed two windows, both of which had dirty windowsills. The window on the left side had a brown coloured spill with cup shaped ring in the spill. The window on the right was dusty, and a dead insect was present on the windowsill. Subsequent observations four and a half hours later revealed the windowsills in the library remained in the same condition as earlier that morning.

In an interview, staff #223 stated that it was the responsibility of housekeeping staff to clean the library, including the windowsills on a daily basis. He/she stated that this cleaning would normally take place in the morning, but had not been completed that day as housekeeping was short staffed.

Staff #223 observed the areas noted by the inspector and concluded that these areas of the home were not kept clean and sanitary. This area of the home was not found to be in compliance by the specific date in March 2017.

c) Observations by the inspector on an identified date in the dining room on an identified floor unit revealed a heating/cooling unit under a window next to the servery area appeared dirty. The grates on the top of the unit were dusty, with debris and a mold-like substance present. Subsequent observations a week later revealed that the heating/cooling unit was in the same condition as previously observed.

In an interview, staff #223 stated that it was the responsibility of housekeeping staff to clean the heating/cooling units in the dining room areas on a daily basis. Staff #223 further stated that it was the responsibility of the contracted housekeeping service to develop and implement housekeeping policies and procedures.

Record review of the contracted housekeeping service schedule of operations daily cleaning duties dated August 2015, revealed cleaning should take place in the dining rooms of the home seven days a week. Cleaning protocols in the dining room included cleaning of all surfaces after a spill has occurred, and the removal of debris and disinfection. Resident occupied areas were to be checked frequently to ensure these areas were free from spills and stains.

In an interview, staff #140 stated that the heating/cooling unit in the above mentioned floor dining room was dirty, and had not been cleaned up to the expectations of the

facility. Staff S #140 confirmed that this area of the home was not kept clean and sanitary. [s. 15. (2) (a)]

2. The license has failed to ensure the home, furnishings and equipment are maintained in a safe condition and in a good state of repair

a) During stage one of the RQI Accommodation Services - Maintenance was triggered related to common areas in disrepair.

Observations by Inspector #589 on an identified date revealed that in the shared washroom of an identified resident room the sink enamel was chipped. Observations by Inspector #643 twelve days later revealed that an approximately one inch by one inch area of the sink enamel on the front of the sink was chipped off, and the front of the sink was damaged at the base of the sink at the front of the counter.

In interviews, staff #103 and #104 stated that maintenance concerns are reported to the maintenance department through an online program and demonstrated knowledge of how to report a maintenance concern. Neither staff #103 nor #104 reported being aware of the chip in the sink enamel in the above mentioned room.

In an interview, staff #144 stated that he/she was unaware of the chip in the sink enamel in the above mentioned resident room and stated that maintenance issues are reported through the online program and repairs are assigned by the supervisor.

In an interview, staff #140 stated that there was no record of the chipped enamel on the sink in the above mentioned resident room in the online maintenance program. He/she stated that each month the maintenance aides were required to complete a monthly room check to identify any maintenance concerns. He/she stated upon observation that it should have been flagged during a monthly room check for repair. Staff #140 stated that the sink in the above mentioned resident room had not been maintained in a safe condition and in a state of good repair.

b) Observations by Inspector #643 on an identified date during stage one of the RQI revealed a large hole in the drywall behind an identified resident bed in an identified room. Subsequent observations 29 days later revealed two holes in the drywall approximately six by twenty inches in size with drywall material hanging out. This drywall damage in the above mentioned room was cited as an area of noncompliance under inspection report and compliance order #2016_353589_0016.

In an interview, staff #140 stated that the area of drywall damage in the above mentioned room had been entered into the online maintenance program three months prior and had not yet been taken care of. Staff #140 stated that this area should have been addressed as it was cited as an area of concern in the previous inspection report and order. The home did not maintain this home area to compliance by the due date of a specific date in March 2017. Staff #140 stated that this area had not been maintained in a safe condition and in a state of good repair.

c) During stage one of the RQI observations by inspectors #507, #589, #643, and #644 revealed concerns related to furnishings in disrepair and maintenance of the home. This area of concern was inspected related to follow-up to compliance order CO #001 under inspection report #2016_353589_0016.

Observations by Inspector #644 on an identified date revealed an area of drywall in the shared washroom of an identified resident room above the baseboard molding was damaged. Subsequent observations one month later by Inspector #643 revealed that an area of drywall had damage above the baseboard in the washroom of the above mentioned resident room.

Observations by Inspector #589 on an identified date revealed that in the shared washroom of another identified resident room the sink was rusty along the side of the sink. Subsequent observations by Inspector #643 one month later revealed an area of the sink near the drain was rusty, and an area of enamel was chipped at the front edge of the sink in the washroom of the above mentioned resident room.

Observations by Inspector #589 on an identified date revealed an area of drywall damaged beside an identified bed in the area of the electrical outlet in an identified room. Subsequent observations by Inspector #643 one month later revealed an area of drywall damaged with a telephone jack cover plate that was displaced due to the structural damage in the drywall in the above mentioned room.

Observations by Inspector #643 on an identified date revealed a hole approximately six by four inches in the drywall behind an identified bed in an identified room. Subsequent observations by the inspector one month later revealed areas of damage in the drywall on both sides of the identified bed in the above mentioned room. Holes approximately six by twelve inches were observed with drywall material falling out onto the floor. Some previous drywall work was evident in this area.

Observations on an identified date by Inspector #643 revealed drywall damage of a hole approximately four by six inches behind an identified bed in an identified room. Subsequent observations by the inspector one month later revealed two holes behind the identified bed in the above mentioned room with some evidence of previous drywall work in the area noted.

Observations on an identified date by Inspector #643 revealed drywall damage behind an identified bed in an identified room. Two holes approximately one by one inch in size were noted behind the identified bed. Subsequent observations by the inspector one month later revealed two holes in the drywall behind the identified bed in the above mentioned room one of which was approximately three by sixteen inches in size. Some evidence of previous drywall repairs was evident in this area.

Record review of the home's electronic maintenance program report revealed that none of the above mentioned areas had been entered into the program for maintenance services to address.

In an interview staff #160 stated that the home had an action plan in place to address some of the maintenance concerns in the building. Renovations in the building were started on an identified floor and would continue until all resident rooms had been completed.

Record review of an action plan prepared by the home on a specific date in March 2017, revealed that each resident washroom would be renovated, removing and replacing drywall, and toilets. In addition, each resident room would be repainted.

In an interview, staff #140 stated that all of the resident rooms were checked by maintenance staff for any maintenance concerns during the monthly room checks during the RQI. Staff #140 confirmed that none of the above mentioned areas were flagged in the monthly room checks to be addressed by maintenance staff. Staff #140 further stated that the home had a renovation plan in place that would remedy the drywall damage in all resident rooms. Staff #140 stated that he/she was looking into some wall protection to prevent further damage behind the resident beds, however that had not been included in the current renovation plans. Staff #140 confirmed that the above mentioned areas of the home were not maintained in a safe condition and in a state of good repair.

d) Observations by the inspector on an identified date on an identified floor unit, outside

an identified bath room revealed that on each side of the doorway to the entrance of the bath room pieces of metal molding hanging off the bottom of the wall with finishing nails present.

In an interview, staff #140 stated that this area had been under construction and the contractors did not leave the area in a safe condition. He/she further stated that this molding should have been secured prior to the contractors leaving the day before. Staff #140 stated that this area was not maintained in a safe condition and in a state of good repair.

The severity of this finding is potential for harm related to cleanliness and disrepair of the home, and furnishings. The scope is a pattern related to this finding being identified in two previous inspections and multiple areas of the home affected. Compliance history revealed that on a specific date in April 2016, under inspection #2016_226192_0013 a compliance order had been served with a specific compliance date in July 2016. On an identified date in December 2016, under inspection #2016_353589_0016 a second compliance order had been served with a specific compliance date in March 2017, due to ongoing noncompliance. As a result of two previous compliance orders having been served and continued noncompliance with LCTHA, 2007 S.O. 2007, c.8, s. 15 (2), a Director's Referral is warranted. [s. 15. (2) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

a) Review of a Critical Incident System (CIS) report submitted to the Ministry of Health and Long Term Care (MOHLTC) revealed that on an identified date at an identified time, resident #070 fell and sustained injuries while being assisted for transfer by staff #114.

Review of the Resident Assessment Instrument - Minimum Date Set (RAI-MDS) assessment and the care plan dated three weeks prior to the above mentioned incident revealed that resident #070 required assistance for transfer.

Review of the above mentioned CIS report and the progress notes of resident #070 revealed that on the above mentioned identified date and the identified time, staff #114 assisted the resident for transfer. During the transfer, resident #070 lost balance, fell and sustained injuries. The resident was sent to the hospital for treatment.

Interview with resident #070 revealed that on the identified date and time, staff #114 assisted him/her with transfer. When he/she lost balance and fell forward, staff #114 was not able to hold the resident and prevent him/her from falling.

Review of the home's "One Person Pivot Transfer" policy (policy #VII-G-20.20(e), effective January 2015), indicated that when assisting resident for one person pivot transfer, the staff should stand on the resident's weaker side facing the resident.

Interview with staff #114 revealed that on the above mentioned date, he/she assisted resident #070 for transfer. Staff #114 stated that he/she was not standing on the resident's weaker side facing the resident. Staff #114 further revealed that he/she was hired one month prior to the above mentioned incident, and received training on mechanical transfer during orientation, but did not receive training for manual transfer.

Review of the education sign-in sheet and interview with staff #114 revealed that the staff received manual transfer training 12 days after the above mentioned incident.

Interview with staff #159 confirmed that staff #114 did not receive manual transfer training prior to assist resident #070 for transfer on the above mentioned date, and staff #114's improper transfer technique did not prevent resident #070 from falling and sustaining injuries because she/he was in an unsafe position rather than beside the resident.

b) On a specific date in December 2016, the home received a compliance order #003 during the Resident Quality Inspection #2016_353589_0016. The grounds for issuing order #003 was that staff #196 did not use safe transferring and positioning devices or techniques when assisting a resident. The order directed the home to ensure that staff use safe transferring and positioning devices or techniques when assisting residents who require assistance with transfers. Part of the order was to provide education to all direct care staff in regards to different types of transfer methods. The home was to be in compliance by a specific date in February 2017.

Record review of resident #068's most recent written plan of care and kardex dated an identified date, indicated the resident required two staff to provide assistance for manual transfer. The resident required assistance from one staff for toilet use and personal care.

An interview with staff #196 on an identified date in April 2017, revealed that staff #196 has been assisting resident #068 for transfer from chair to toilet with one person if the resident was able to weight bear and cooperative, and has been assisting resident #068 for transfer from bed to chair and chair to bed with two people. Staff #196 stated that resident #068's kardex indicated the resident required two people to provide assistance for transfer, and one person assistance for toilet use and personal care, and the resident was transferred manually. Staff #196 further stated that his/her understanding was to assist the resident with one person for toilet use, included transferring the resident from chair to toilet, according to the kardex.

Interview with staff #159 revealed that staff #196 did not understand the definition of "transfer", and further stated the definition of transfer was to move a resident from one place to another which was included in the transfer training material. Staff #159 confirmed that staff #196 did not use safe techniques when providing assistance to transfer resident #068.

Interview with staff #159 revealed that transfer training included mechanical and manual transfers. Mechanical transfer training was provided by one of the nurse managers, and the manual transfer training was provided by the physiotherapist. Record review of the Lifts & Transfers Education Inservice for 2016 and 2017 and sign in sheets, and interview with staff #159 revealed that 44 per cent of direct care staff did not receive mechanical and manual transfers training as of the compliance due date of compliance order #003. Record review of the Lifts & Transfers Education Inservice for 2016 and 2017 record indicated staff #196 received mechanical transfer training in April 2016 and manual

transfer training on a specific date in March 2017.

The severity is potential for actual harm related to unsafe transferring technique, and the scope is a widespread as 44 per cent of staff did not receive the safe transferring training. The previous compliance history revealed two compliance orders had been served under inspection #2015_324567_0016 and #2016_353589_0016. The compliance date for inspection #2016_353589_0016 was a specific date in February 2017. As a result of this ongoing non-compliance with O. Reg. 79/10, s. 36, a compliance order and a Director Referral is warranted. [s. 36.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: 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).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's 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 was fully respected and promoted.

Review of an identified CIS report revealed an incident of alleged abuse of resident #032 by staff #186 on an identified date. The CIS report stated that resident #032 asked staff #186 to assist him/her with toileting and staff #186 made a comment that it was the resident's concern and did not toilet resident #032. This interaction was witnessed by resident #033.

Record review of resident #032's plan of care revealed he/she required the assistance of two staff members for toileting.

In an interview, resident #032 stated that staff #186 was rude, nasty and resident #032 thought staff #186 should have more respect for him/her. Resident #032 stated that it was always a big deal when he/she needed to be toileted because he/she required two person assistance. Resident #032 stated that on the above mentioned date, he/she rang the call bell in his/her washroom for toileting assistance. Resident #032 stated that staff #186 was away from the unit and staff told resident #032 that staff #186 would assist on returning to the unit. Resident #032 stated that staff #186 returned to the unit and when resident #032 requested toileting assistance staff #186 told him/her that it was the resident's concern and walked away. According to resident #032 staff #186 did not assist him/her with toileting and left at the end of the shift.

In an interview, resident #033 stated that he/she witnessed the interactions between resident #032 and staff #186. Resident #033 stated that staff #186 told resident #032 that it was the resident's concern when requesting toileting assistance and did not assist resident #032 with toileting. Resident #033 further stated that staff #186 was frequently complaining and asking the residents if they knew how many people staff #186 needed to look after.

In an interview, staff #121 stated that staff #186 had been suspended as a result of the interactions with resident #032. Staff #121 stated that staff #186 had been coached repeatedly regarding his/her approach to residents. Staff #121 further stated that based on the accounts of resident #032 and #033 that resident #032 had not been treated with courtesy and respect by staff #186. In this case the licensee has failed to ensure that the resident #032's right to be treated with courtesy and respect and in a way that fully recognized resident #032's individuality and dignity was fully respected and promoted. [s. 3. (1) 1.]

2. The licensee has failed to ensure that the resident's right to be afforded privacy in treatment and caring for his or her personal needs was fully respected and promoted.

Review of an identified CIS report revealed that resident #034 had reported to the Nurse Manager that on an identified date, the shower door was left open when he/she was being assisted with showering and a co-resident walked into the shower room.

In an interview, resident #034 stated that on a specified date, he/she was being assisted with showering by staff #182 when resident #037 entered the shower room to look for something. Resident #034 stated that he/she saw resident #037 approach the care cart which was located next to the shower stall and resident #037 could have seen resident #034 while in the shower. Resident #034 stated that he/she did not hear the door open or keypad code sound, so he/she was not certain if the door was open or closed. Resident #034 stated that he/she was aware that resident #037 knew the code to get in the shower room and could enter independently.

In an interview, resident #037 stated that he/she entered the shower room while a resident was being showered to look for a pair of pants that he/she thought were left behind in the morning. Resident #037 further stated that he/she knew the door code for the shower room and was able to enter without assistance of staff.

In interviews, staff #182, #173 and #176 stated that resident #037 knew the door code and could enter the shower room without assistance of staff members. Staff #176 stated that resident #037 should knock on the door and not enter the shower room without staff for supervision.

In an interview, staff #182 stated that he/she had assisted resident #034 with showering and that resident #034 entered the shower room and was asking for something. Staff #182 stated that he/she was focusing on assisting resident #034 with his/her shower and did not see resident #037 and was unsure if resident #037 had been able to see resident #034.

In an interview, staff #121 stated that in order to provide privacy the door to the shower room should be closed, and is secured with a coded keypad. He/she further stated that residents should not have the code to prevent unsupervised access to the shower room. Staff #121 stated that as resident #037 had accessed the shower room while resident #034 was being assisted with showering that resident #034's right to be afforded privacy in treatment and caring for his or her personal needs was not fully respected and

promoted. [s. 3. (1) 8.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's 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, and the resident's right to be afforded privacy in treatment and caring for his or her personal needs are fully respected and promoted, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

a) A CIS report was submitted to the MOHLTC on an identified date regarding an incident of alleged staff to resident abuse that had occurred two days prior. The CIS report revealed the Director had been notified and a reference number had been provided.

The CIS report further revealed that resident #019 had complained staff #166 and #170 had been rough when transferring him/her manually onto the toilet seat.

Review of resident #019's health record revealed he/she had been admitted four days prior to the above mentioned incident, and physiotherapist staff #119 had completed an assessment the next day after admission. Staff #119's assessment revealed that resident #019 required one to two staff manual assist for transfers.

In interviews, staff #166 and #170 stated that on the above mentioned identified date, they had performed a two person manual transfer from bed to chair and then onto the toilet. Staff #166 stated that they were strained trying to hold resident #019 while transferring him/her to the toilet causing the transfer to be rough. Staff #166 and #170 also stated that resident #019 had not wanted to transfer back to bed but had requested to remain up in the chair.

Review of resident #019's most recent plan of care revealed that 10 days after the above mentioned incident, staff #123 had updated the care plan to indicate that resident #019 required the use of a mechanical lift for transfers. Staff #123 further stated that resident #019 had been experiencing difficulty transferring manually for some time.

Review of the assessment tab under point click care (PCC) for resident #019 revealed he/she had experienced falls on two days in the month of admission and that PT referrals had not been completed.

In an interview, staff #123 stated she had been observing staff using the mechanical lift to transfer resident #019 for quite some time and had updated the care plan to indicate the change in transfer status. Staff #123 further stated he/she had assumed staff #119 had been aware and therefore had not completed a referral.

In an interview, staff #119 stated he/she had assessed resident #019 after the above two mentioned fall incidents and his/her assessment had concluded resident #019 continued to require the assistance of one to two staff for manual transfers.

In an interview, staff #119 stated he/she had not received a referral and therefore was not aware that resident #019 was being transferred with a mechanical lift. Staff #119 agreed that staff and others involved in different aspects of care of resident #109 had not collaborated with each other in the assessment of the resident so that their assessments were integrated and consistent and complemented each other.

b) The Ministry of Health and Long-Term Care received a complaint on an identified date regarding a family's concern of the deterioration of resident #051's altered skin integrity. In interviews, the family members (FM) stated they were aware of the altered skin integrity on an identified date. They further stated they were not aware the altered skin integrity had worsened for a period of three months.

Record Review of the initial Wound Assessment on an identified date indicated the measurements of the above mentioned altered skin integrity captured by digital WoundZoom camera.

Record review of resident #051's Weekly wound assessments completed for a period of five months failed to indicate the deterioration and the measurements of the altered skin integrity. On an identified date, five months after the discovery of the altered skin integrity, the Physician completed an assessment of the altered skin integrity on the request of the family.

In interviews, staff #150 and staff #174 acknowledged they failed to notify the Physician, FM and Skin and Wound Coordinator with the wounds deterioration over the above mentioned five months period.

In interviews, Physician #216 and Staff #100 confirmed they were not notified when resident #051's above mentioned altered skin integrity deteriorated.

In an interview, staff #115 stated the home's expectations are when residents are exhibiting altered skin integrity staff are to complete a skin assessment which includes the wound measurements and ensure the notification of the Physician and Wound Care Coordinator of the changes.

PLEASE NOTE: Areas of non-compliance related to resident #051 are included in this inspection report and correspond with inspection report #2017_430644_0004. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the resident is given an opportunity to participate fully in the development and implementation of the resident's plan of care.

On an identified date, resident #081's Substitute Decision Maker (SDM) made a complaint to the MOHLTC where he/she indicated the resident's weight had changed significantly over a period of one year and had impacted on his/her medical condition. The SDM stated that he/she met with the home a year earlier and developed a meal plan to help stabilize the resident's medical condition and weight, and the home did not follow the plan. The SDM also reported that resident #081 was capable of making his/her own decisions.

In an interview, resident #081 indicated an awareness that the SDM requested a therapeutic diet in managing weight changes, and to stabilize his/her medical condition. The resident further expressed an interest in managing weight changes; however, the home did not provide him/her with the opportunity to participate in the development and implementation of the plan of care.

Review of resident #081's health records failed to reveal an entry supporting the resident's participation in the development and implementation of the plan of care. Progress note dated on an identified date entered by staff #147, indicated that he/she contacted the SDM to discuss the resident's significant weight changes in the past year; and the SDM was strongly in favour of a therapeutic diet in managing the significant weight changes. In a progress note dated one year after the previous entry, staff #147 indicated that resident #081 did not have any desire to manage significant weight changes and dietary instructions had come entirely from the resident's SDM, and not the resident. Staff #147 also indicated the resident exhibited a lack of concern for any dietary instructions by not following the meal plan.

In an interview, staff #147 confirmed that he/she had not interviewed resident #081 since admission to the home because of a language barrier. Staff #147 stated there was a plan to interview the resident along with a staff who speaks resident #081's language to assist the resident in the development and implementation of the resident's plan of care; however, the meeting with the resident had not occurred. [s. 6. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staff and others involved in different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other and the resident is given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #5: 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 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 is complied with.

O. Reg. 79/10, under s. 135 (1), requires that every licensee of a long-term care shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident, resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the

resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy provider.

(2) In addition to the requirements under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed,
(b) corrective action is taken as necessary, and
(c) a written record is kept of everything required under clauses (a) and (b).

A CIS report was submitted to the MOHLTC related to a missing medication for resident #016. The CIS report revealed the medication that had been applied on resident #016 on an identified date was noted missing three days later by staff #129.

In an interview, staff #159 stated the home adhered to their pharmacy provider's policy related to medication incidents.

Review of the pharmacy provicer's policy titled "Medication Incidents" last reviewed January 17, 2017, revealed a medication incident report must be completed promptly and sent to the Director of Nursing/Care. All pertinent information should be included especially reasons or contributing factors, so that proper measures may be taken to prevent recurrence of similar incidents.

Review of the home's medication incident reports binder failed to reveal a medication incident report in regards to the above mentioned missing medication. Review of the CIS report binder kept by the home revealed two identified CIS reports had been submitted to the MOHLTC on two identified dates in November 2016, related to missing medication for resident's #016 and #070.

In an interview, staff #129 stated he/she had left a notation on the medication tracking sheet indicating the medication was missing and further stated attempts to notify staff #115 immediately were unsuccessful. RN #129 also stated that he/she had not completed a medication incident report promptly when the medication was found missing.

In an interview, staff #159 stated that during drug destruction with the pharmacy consultant two months after the above missing medication was discovered. Staff #159 confirmed that a medication incident report was not completed until 71 days later. Staff further stated medication incident reports had not been completed for the above

mentioned two CIS reports for the previous two missing medication incidents and therefore the home had not complied with completing medication incident reports promptly. [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 to ensure that 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 is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from abuse by anyone.

A CIS was submitted to the MOHLTC on an identified date related to an incident of staff to resident abuse that had occurred the day before. The CIS report revealed during an activity program in the dining room on an identified floor, staff #152 overheard staff #151 yelling at someone to stop kicking the equipment. Staff #152 went into the dining room and observed staff #151 yelling at resident #018 to stop touching the equipment and not to kick it. The CIS report further revealed that staff #151 left the dining room and stated to staff #152 that he/she was going to call the police. Upon re-entering the dining room staff #151 continued to speak in an elevated tone towards resident #018 to not touch the above mentioned equipment.

Review of the home's investigation notes revealed staff #121 interviewed resident #018 the day after the above mentioned incident and he/she did not recall that staff #151 had yelled at him. Resident #018 could not be interviewed for this inspection as he/she was not resided in the home during the RQI.

In an interview, staff #151 stated that during the activity program resident #018 had requested a tool to play. When staff #151 was delayed in providing him/her with it resident #018 began to kick the equipment. Staff #151 further stated he/she had yelled at resident #018 to stop kicking the equipment and he/she confirmed speaking to the resident in that way was abusive.

Review of staff #151'a employee file revealed there had been a previous incident of abuse involving resident #018 in the previous year, where he/she had received a written discipline. The employee file further revealed that for the current incident staff #151 received a three day suspension for verbal abuse towards resident #018.

In an interview, staff #149 stated that he/she had overheard staff #151 speaking in a raised voice as he/she was exiting the activity program taking place in the dining room and had told him/her not to shout.

In an interview, staff #152 stated that he/she had overheard staff #151 yelling at resident #018 during the activity program however he/she had not witnessed resident #018 kicking the equipment. Staff #152 confirmed resident #018 had not been protected from abuse from staff #151. [s. 19. (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 to ensure that residents are protected from abuse by anyone, to be implemented voluntarily.

WN #7: 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 to the Director.

An identified CIS was submitted to the MOHLTC in which staff #151 was overheard yelling at resident #018 during an activity program on an identified date by staff #152.

Review of the CIS report revealed the above mentioned incident was reported to the DOC the same day, however the Director was not notified until the next day.

In an interview, staff #159 confirmed that the above mentioned incident of abuse had not been reported immediately to the Director as per legislative requirements under O. Reg. s. 24. (1). [s. 24. (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 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 to the Director, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity is assessed by a registered dietitian who is a member of the staff of the home.

On an identified date, resident #081's SDM made a complaint to the MOHLTC related to altered skin integrity that had been taking a long time to heal.

In an interview, staff #228 indicated that on an identified date, the assigned staff to resident #081 reported altered skin integrity.

Review of resident #081's progress notes revealed altered skin integrity that was reported on an identified date, and was assessed by staff #228. Review of resident #081's health record since the report of altered skin integrity failed to reveal an assessment by a RD related to the resident's altered skin integrity.

In an interview, staff #228 stated that he/she did not refer resident #081 to the RD for a nutritional assessment in relation to the above mentioned altered skin integrity. Staff #228 stated it was the home's expectation that residents exhibiting altered skin integrity be referred to the RD for a nutritional assessment.

In an interview, staff #147 confirmed that he/she did not complete a nutritional assessment related to the above mentioned altered skin integrity for resident #081. [s. 50. (2) (b) (iii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity is assessed by a registered dietitian who is a member of the staff of the home, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible.

An identified CIS report was submitted to the MOHLTC related to an incident of alleged staff to resident abuse. The CIS report revealed that resident #024 had demonstrated responsive behaviours in the evening and the night on an identified date. Attempts by registered staff to administer as needed (PRN) medication to manage the resident's responsive behaviours had also been unsuccessful.

Review of resident #024's health record revealed a history of demonstrating responsive behaviours.

Review of resident #024's written plan of care revealed the following strategies had been developed:
-staff to monitor of signs of responsive behaviours and to approach in a calm manner explaining to him/her prior to care, what will be done,
-two staff for care when he/she has responsive behaviours,
-staff to improve behavior by redirection and reassurance, and
-staff to leave and re-approach at a later time to gain compliance.

Review of progress notes for resident #024 on the above mentioned date revealed he/she had demonstrated responsive behaviours and PRN medication prescribed to manage responsive behaviours throughout the day and evening shifts.

In an interview, staff #212 stated that on the above mentioned date, resident #024 had demonstrated responsive behaviours. Staff #212 further stated resident #024 had refused the administration of PRN medications to manage the responsive behaviours he/she had been demonstrating that day.

In an interview, staff #210 stated resident #024 had been received up in his/her chair at the evening to night shift exchange. Staff #210 further stated he/she had instructed staff #170 to leave resident #024 up and to re-approach at a later time as the above mentioned responsive behaviours continued to be demonstrated.

In an interview, staff #170 stated resident #024 continued to exhibit responsive behaviours throughout the night. Staff #170 further stated that at an identified time he/she approached resident #024 to provide personal care however, staff #170's attempts to provide personal care were unsuccessful. Staff #170 requested the assistance of staff #198 in an attempt to provide care.

In an interview, staff #198 stated resident #024 agreed to be transferred to bed after he/she explained the care to be provided. Staff #198 further stated he/she was able to apply the transfer sling and when two other co-workers entered the resident room with the mechanical lift and began to hook the transfer sling to the lift, resident #024 became agitated striking out at them and striking his hands on the lift.

In interviews, staff #170 and #198 stated they were standing on either side of resident #024 and to protect resident #024 from further injury they each held on to his hands/wrists area to complete the transfer. When they released their hands from resident #024's hands they noted skin tears had occurred.

Staff #170 and #198 both realized that when resident #024 became agitated they should have left and re-approached at a later time as per strategies identified in resident #024's plan of care.

In an interview, staff #115 agreed that staff #170 and #198 had failed to implement strategies that had been developed for resident #024 when he/she demonstrated responsive behaviours. [s. 53. (4) (b)]

2. An identified CIS report was submitted to the MOHLTC related to an incident of alleged staff to resident abuse on an identified date. The CIS report revealed staff #165

was witnessed hitting resident #079 when the resident refused to give things he/she was holding to the staff when asked.

Review of the home's investigation notes and an interview with staff #165 revealed that on the above mentioned date, staff #165 was in the dining room on an identified floor in front of the steamer. Resident #079 was standing beside him/her holding some napkins in a wrapper. Staff #165 asked resident #079 to give him/her the napkins, and the resident refused. Two minutes later, staff #165 removed the napkins from the wrapper without asking the resident. When resident #079 realized staff #165 took the napkins, he/she hit the staff with a fist. Staff #165 told the resident not to hit him/her. When resident #079 raised his/her hand and attempted to hit the staff again, staff #165 put out his/her left hand to block the hit, and his/her left hand collided with resident #079's right arm.

Review of resident #079's care plan revealed that one of the interventions for the resident's responsive behaviours was to be patient and use calm tone when redirecting the resident.

Interview with staff #165 revealed that he/she was aware of resident #079's responsive behaviours, and the interventions included leaving him/her alone and re-approach at a later time. Staff #165 further revealed that when he/she re-approached the resident, he/she should talk to the resident instead of removing the napkins from the wrapper without telling the resident what he/she was going to do.

Interview with staff #121 revealed that staff #165 should follow the Gentle Persuasive Approach (GPA) when interacting with residents. Staff #121 confirmed that staff #165 did not implement the interventions developed for resident #079 when approaching the resident the second time on the above mentioned date. [s. 53. (4) (b)]

3. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

Review of an identified CIS report and interview with staff #215 revealed that an altercation between two residents had occurred on an identified date. The CIS report revealed that on the above mentioned identified date at an identified time, resident #084 was having a beverage in the common area of an identified unit. Resident #085

approached resident #084 and yelled at the resident. Resident #084 told resident #085 to go away. When resident #085 continued to instigate the situation, resident #084 threw the cup at resident #085, and hit resident #085. Resident #085 then slapped resident #084 twice. The residents were separated immediately by staff.

Review of the above mentioned CIS report and progress notes of residents #084 and #085 revealed that skin and pain assessments were conducted on both residents. Both residents were placed on monitoring. Review of resident #085's health record with staff #112 failed to reveal the completed monitoring record after the above mentioned incident occurred on the above mentioned identified date.

Interview with staff #121 revealed that the home's expectation was to initiate the monitoring for one week on admission and when the resident exhibited responsive behaviours. After one week of monitoring, registered staff were to review and analyze the trend of the responsive behaviour and document in the progress notes.

Review of the progress notes of resident #085 failed to reveal the analysis of the monitoring for the resident after the above mentioned incident. Interview with staff #121 confirmed that the intervention of monitoring and the analysis of resident #085's responsive behaviour were not documented. [s. 53. (4) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible and for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident height is measured and recorded upon admission and annually thereafter.

Census record reviews in stage one of the RQI revealed that heights had not been measured and recorded on admission for two residents and annually for nine residents.

Review of the home's policy titled "Height Measurement" (policy number VII-G-20.90, revised December 2016) revealed residents' heights are taken within 48 hours of admission, annually and whenever there is a significant change.

Review of PCC under the weights/vitals tab revealed residents #001 and #020 did not have heights measured and recorded on admission.

In interviews during stage one of the RQI, staff #104 and #102 stated that heights are to be taken on admission and annually thereafter and confirmed that admission heights for residents #020 and #001, respectively, had not been completed.

Review of PCC under the weights/vitals tab revealed the residents #002, #003, #004, #036, #057, #058, #076. #077 and #078 did not have their annual heights completed.

In an interview, staff #159 stated the home's expectation is that heights are taken on admission, with change of condition and annually thereafter. [s. 68. (2) (e) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for each resident height is measured and recorded upon admission and annually thereafter, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

**s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a dining and snack service that included proper techniques to assist residents with eating, including safe positioning of residents who required assistance.

Observations by the inspector on an identified date at an identified time revealed resident #038 seated in a tilted position at approximately 27.5 degrees while being assisted with feeding by staff #211. Upon observation resident #038 did not appear to be in distress and was not observed to be choking.

Record review of resident #038's plan of care revealed that the resident required assistance from one staff member for eating. The plan of care noted resident #038 was at risk of aspiration and staff were instructed to monitor him/her while eating.

In an interview staff #129 stated that it was the expectation of the home to ensure that residents are seated in an upright position when being assisted with feeding.Staff #129 further stated that assisting a resident who is in a tilted position put the resident at increased risk of aspiration. In this case the licensee has failed to ensure that the home had a dining and snack service that included proper techniques to assist residents with eating, including safe positioning of residents who required assistance. [s. 73. (1) 10.]

2. The licensee has failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

Observations by the inspector in an identified dining room on an identified date at an identified time revealed resident #023 seated in a tilted wheelchair tilted back at approximately 30 degrees. Upon observation a plated entrée was sitting on the dining table in front of the resident. No staff members were present at the table to assist resident #023 with eating. Three minutes later staff #216 adjusted resident #023's tilt wheelchair so that the resident was seated upright, then staff #216 sat down next to resident #023 and began to assist him/her with eating.

Record review of resident #023's plan of care revealed that he/she required assistance from one staff member for the activity of eating.

In interviews, staff #216 and #176 stated that it was the expectation of the home for residents who require assistance with eating or drinking to not be served until a staff member was available to provide the required assistance. Staff #176 stated that resident #023 should not have been served his/her meal until staff #216 was available to provide assistance to resident #023. In this case the licensee has failed to ensure that resident #023 who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident. [s. 73. (2) (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 to ensure that the home had a dining and snack service that included proper techniques to assist residents with eating, including safe positioning of residents who required assistance and no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is reported to the pharmacy service provider.

An identified CIS report was submitted to the MOHLTC on an identified date related to a missing medication for resident #016. The CIS report revealed the medciation that had been applied on resident #016 on an identified date was noted missing three days later by staff #129.

In an interview,staff #159 stated the home adhered to their pharmacy provider’s policy related to medication incidents.

Review of the pharmacy provider’s policy titled "Medication Incidents", last reviewed January 17, 2017, revealed medication incident reports will be analyzed by nursing administration, the pharmacy manager and/or the consultant pharmacist to determine whether pharmacy and/or nursing procedures require modification.

Review of CIS reports submitted to the MOHLTC revealed there had been two previous incidents of missing medication on two identified dates in November 2016.

In an interview, the pharmacy consultant staff #181 stated he/she had not received a medication incident report for the missing medication and therefore had not completed an analysis. Staff #181 further stated that the missing medication had been discovered during drug destruction two months later that was conducted with staff #159. Staff #181 also stated he/she had not been aware of a CIS report for resident #016 and another CIS report for resident #070 where medication had been reported missing on two identified dates in November 2016.

In an interview, staff #159 confirmed that the pharmacy consultant had not been notified of the three above mentioned medication incidents related to missing medication. [s. 135. (1)]

Issued on this 31st day of May, 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) :	STELLA NG (507), ADAM DICKEY (643), ANGIE KING (644), FAYLYN KERR-STEWART (664), JOANNE ZAHUR (589), MATTHEW CHIU (565)
Inspection No. / No de l'inspection :	2017_644507_0003
Log No. / Registre no:	005039-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 24, 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
	Sara Rooney

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Administrator /
Nom de l'administratrice ou de l'administrateur :

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)

Linked to Existing Order / Lien vers ordre existant: 2016_353589_0016, CO #001;

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 the home, furnishings and equipment are kept clean and sanitary, and are maintained in a safe condition and in a good state of repair.

Upon receipt of this order, the licensee shall ensure the following:
- a system is developed for a staff member of the home to audit the cleanliness and sanitation of the home, furnishings and equipment including shower rooms and all resident home areas,
-cleaning and sanitation procedures are followed in order to keep the home, furnishings and equipment are kept clean and sanitary,
- maintenance staff receive re-training on policies and procedures of the home to ensure that maintenance issues are identified and prioritized, and
- maintenance issues are addressed to keep the home, furnishings and equipment are maintained in a safe condition and a state of good repair.

Grounds / Motifs :

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

Two Compliance Orders were served under inspection report # 2016_226192_0013 and #2016_353589_0016 related to housekeeping and

maintenance services in the home. Compliance Order #001 under inspection report #2016_353589_0016 directed the licensee to prepare, submit and implement a plan to achieve compliance in the areas of housekeeping and maintenance. The licensee was ordered to develop schedules to ensure that the home was kept clean and sanitary and in a state of good repair. The home was ordered to be in compliance by a specific date in March 2017.

a) On multiple occasions during the Resident Quality Inspection (RQI), the inspectors made several observations and interviews with staff related to the cleanliness of the home.

- a dark mold/mildew like substance at the base of the tiles in the shower stall in one of the bath rooms on an identified floor,
- tiles in the lower portion of the shower stall walls were dirty with a mold/mildew like substance in one of the bath rooms on another identified floor, and
- black areas of a mold/mildew like substance on the grout of the lower tiles in the shower stall in one of the bath rooms on two other identified floors.

In an interview, staff #223 stated that the expectation of the home is for the shower stalls to be wiped clean by the assigned housekeeping aide on each floor daily using orange cleaner. Staff #223 further stated that deep cleaning is completed once monthly in the bath rooms, including scrubbing of the shower stalls.

In an interview, staff #140 stated that housekeeping services in the home were provided by a contracted vendor which was responsible for developing procedures for cleaning in the home. Staff #140 stated that the expectation of the home is for shower stalls to be clean and free of mold/mildew. He/she further stated that these areas had not been cleaned up to the expectations of the facility. Staff #140 confirmed that these areas of the home were not kept clean and sanitary.

b) The resident library was observed for cleanliness as part of follow-up inspection of CO #001 under inspection report #2016_353589_0016 as the window areas of the library had been found to be in an unclean state during the RQI.

Observations by the inspector on an identified date in the resident library located on the ground floor of the home revealed two windows, both of which had dirty

windowsills. The window on the left side had a brown coloured spill with cup shaped ring in the spill. The window on the right was dusty, and a dead insect was present on the windowsill. Subsequent observations four and a half hours later revealed the windowsills in the library remained in the same condition as earlier that morning.

In an interview, staff #223 stated that it was the responsibility of housekeeping staff to clean the library, including the windowsills on a daily basis. He/she stated that this cleaning would normally take place in the morning, but had not been completed that day as housekeeping was short staffed.

Staff #223 observed the areas noted by the inspector and concluded that these areas of the home were not kept clean and sanitary. This area of the home was not found to be in compliance by the specific date in March 2017.

c) Observations by the inspector on an identified date in the dining room on an identified floor unit revealed a heating/cooling unit under a window next to the servery area appeared dirty. The grates on the top of the unit were dusty, with debris and a mold-like substance present. Subsequent observations a week later revealed that the heating/cooling unit was in the same condition as previously observed.

In an interview, staff #223 stated that it was the responsibility of housekeeping staff to clean the heating/cooling units in the dining room areas on a daily basis. Staff #223 further stated that it was the responsibility of the contracted housekeeping service to develop and implement housekeeping policies and procedures.

Record review of the contracted housekeeping service schedule of operations daily cleaning duties dated August 2015, revealed cleaning should take place in the dining rooms of the home seven days a week. Cleaning protocols in the dining room included cleaning of all surfaces after a spill has occurred, and the removal of debris and disinfection. Resident occupied areas were to be checked frequently to ensure these areas were free from spills and stains.

In an interview, staff #140 stated that the heating/cooling unit in the above mentioned floor dining room was dirty, and had not been cleaned up to the expectations of the facility. Staff S #140 confirmed that this area of the home was not kept clean and sanitary. [s. 15. (2) (a)]

2. The license has failed to ensure the home, furnishings and equipment are maintained in a safe condition and in a good state of repair

a) During stage one of the RQI Accommodation Services - Maintenance was triggered related to common areas in disrepair.

Observations by Inspector #589 on an identified date revealed that in the shared washroom of an identified resident room the sink enamel was chipped. Observations by Inspector #643 twelve days later revealed that an approximately one inch by one inch area of the sink enamel on the front of the sink was chipped off, and the front of the sink was damaged at the base of the sink at the front of the counter.

In interviews, staff #103 and #104 stated that maintenance concerns are reported to the maintenance department through an online program and demonstrated knowledge of how to report a maintenance concern. Neither staff #103 nor #104 reported being aware of the chip in the sink enamel in the above mentioned room.

In an interview, staff #144 stated that he/she was unaware of the chip in the sink enamel in the above mentioned resident room and stated that maintenance issues are reported through the online program and repairs are assigned by the supervisor.

In an interview, staff #140 stated that there was no record of the chipped enamel on the sink in the above mentioned resident room in the online maintenance program. He/she stated that each month the maintenance aides were required to complete a monthly room check to identify any maintenance concerns. He/she stated upon observation that it should have been flagged during a monthly room check for repair. Staff #140 stated that the sink in the above mentioned resident room had not been maintained in a safe condition and in a state of good repair.

b) Observations by Inspector #643 on an identified date during stage one of the RQI revealed a large hole in the drywall behind an identified resident bed in an identified room. Subsequent observations 29 days later revealed two holes in the drywall approximately six by twenty inches in size with drywall material hanging out. This drywall damage in the above mentioned room was cited as an

area of noncompliance under inspection report and compliance order #2016_353589_0016.

In an interview, staff #140 stated that the area of drywall damage in the above mentioned room had been entered into the online maintenance program three months prior and had not yet been taken care of. Staff #140 stated that this area should have been addressed as it was cited as an area of concern in the previous inspection report and order. The home did not maintain this home area to compliance by the due date of a specific date in March 2017. Staff #140 stated that this area had not been maintained in a safe condition and in a state of good repair.

c) During stage one of the RQI observations by inspectors #507, #589, #643, and #644 revealed concerns related to furnishings in disrepair and maintenance of the home. This area of concern was inspected related to follow-up to compliance order CO #001 under inspection report #2016_353589_0016.

Observations by Inspector #644 on an identified date revealed an area of drywall in the shared washroom of an identified resident room above the baseboard molding was damaged. Subsequent observations one month later by Inspector #643 revealed that an area of drywall had damage above the baseboard in the washroom of the above mentioned resident room.

Observations by Inspector #589 on an identified date revealed that in the shared washroom of another identified resident room the sink was rusty along the side of the sink. Subsequent observations by Inspector #643 one month later revealed an area of the sink near the drain was rusty, and an area of enamel was chipped at the front edge of the sink in the washroom of the above mentioned resident room.

Observations by Inspector #589 on an identified date revealed an area of drywall damaged beside an identified bed in the area of the electrical outlet in an identified room. Subsequent observations by Inspector #643 one month later revealed an area of drywall damaged with a telephone jack cover plate that was displaced due to the structural damage in the drywall in the above mentioned room.

Observations by Inspector #643 on an identified date revealed a hole approximately six by four inches in the drywall behind an identified bed in an

identified room. Subsequent observations by the inspector one month later revealed areas of damage in the drywall on both sides of the identified bed in the above mentioned room. Holes approximately six by twelve inches were observed with drywall material falling out onto the floor. Some previous drywall work was evident in this area.

Observations on an identified date by Inspector #643 revealed drywall damage of a hole approximately four by six inches behind an identified bed in an identified room. Subsequent observations by the inspector one month later revealed two holes behind the identified bed in the above mentioned room with some evidence of previous drywall work in the area noted.

Observations on an identified date by Inspector #643 revealed drywall damage behind an identified bed in an identified room. Two holes approximately one by one inch in size were noted behind the identified bed. Subsequent observations by the inspector one month later revealed two holes in the drywall behind the identified bed in the above mentioned room one of which was approximately three by sixteen inches in size. Some evidence of previous drywall repairs was evident in this area.

Record review of the home's electronic maintenance program report revealed that none of the above mentioned areas had been entered into the program for maintenance services to address.

In an interview staff #160 stated that the home had an action plan in place to address some of the maintenance concerns in the building. Renovations in the building were started on an identified floor and would continue until all resident rooms had been completed.

Record review of an action plan prepared by the home on a specific date in March 2017, revealed that each resident washroom would be renovated, removing and replacing drywall, and toilets. In addition, each resident room would be repainted.

In an interview, staff #140 stated that all of the resident rooms were checked by maintenance staff for any maintenance concerns during the monthly room checks during the RQI. Staff #140 confirmed that none of the above mentioned areas were flagged in the monthly room checks to be addressed by maintenance staff. Staff #140 further stated that the home had a renovation plan

in place that would remedy the drywall damage in all resident rooms. Staff #140 stated that he/she was looking into some wall protection to prevent further damage behind the resident beds, however that had not been included in the current renovation plans. Staff #140 confirmed that the above mentioned areas of the home were not maintained in a safe condition and in a state of good repair.

d) Observations by the inspector on an identified date on an identified floor unit, outside an identified bath room revealed that on each side of the doorway to the entrance of the bath room pieces of metal molding hanging off the bottom of the wall with finishing nails present.

In an interview, staff #140 stated that this area had been under construction and the contractors did not leave the area in a safe condition. He/she further stated that this molding should have been secured prior to the contractors leaving the day before. Staff #140 stated that this area was not maintained in a safe condition and in a state of good repair.

The severity of this finding is potential for harm related to cleanliness and disrepair of the home, and furnishings. The scope is a pattern related to this finding being identified in two previous inspections and multiple areas of the home affected. Compliance history revealed that on a specific date in April 2016, under inspection #2016_226192_0013 a compliance order had been served with a specific compliance date in July 2016. On an identified date in December 2016, under inspection #2016_353589_0016 a second compliance order had been served with a specific compliance date in March 2017, due to ongoing noncompliance. As a result of two previous compliance orders having been served and continued noncompliance with LCTHA, 2007 S.O. 2007, c.8, s. 15 (2), a Director's Referral is warranted. [s. 15. (2) (c)] (643)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 22, 2017

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2016_353589_0016, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee shall ensure that all direct care staff are provided training in safe transferring and positioning devices or techniques when assisting residents.

Grounds / Motifs :

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

a) Review of a Critical Incident System (CIS) report submitted to the Ministry of Health and Long Term Care (MOHLTC) revealed that on an identified date at an identified time, resident #070 fell and sustained injuries while being assisted for transfer by staff #114.

Review of the Resident Assessment Instrument - Minimum Date Set (RAI-MDS) assessment and the care plan dated three weeks prior to the above mentioned incident revealed that resident #070 required assistance for transfer.

Review of the above mentioned CIS report and the progress notes of resident #070 revealed that on the above mentioned identified date and the identified time, staff #114 assisted the resident for transfer. During the transfer, resident #070 lost balance, fell and sustained injuries. The resident was sent to the hospital for treatment.

Interview with resident #070 revealed that on the identified date and time, staff #114 assisted him/her with transfer. When he/she lost balance and fell forward, staff #114 was not able to hold the resident and prevent him/her from falling.

Review of the home's "One Person Pivot Transfer" policy (policy #VII-G-20.20(e), effective January 2015), indicated that when assisting resident for one person pivot transfer, the staff should stand on the resident's weaker side facing the resident.

Interview with staff #114 revealed that on the above mentioned date, he/she assisted resident #070 for transfer. Staff #114 stated that he/she was not standing on the resident's weaker side facing the resident. Staff #114 further revealed that he/she was hired one month prior to the above mentioned incident, and received training on mechanical transfer during orientation, but did not receive training for manual transfer.

Review of the education sign-in sheet and interview with staff #114 revealed that the staff received manual transfer training 12 days after the above mentioned incident.

Interview with staff #159 confirmed that staff #114 did not receive manual transfer training prior to assist resident #070 for transfer on the above mentioned date, and staff #114's improper transfer technique did not prevent resident #070 from falling and sustaining injuries because she/he was in an unsafe position rather than beside the resident.

b) On a specific date in December 2016, the home received a compliance order #003 during the Resident Quality Inspection #2016_353589_0016. The grounds for issuing order #003 was that staff #196 did not use safe transferring and positioning devices or techniques when assisting a resident. The order directed the home to ensure that staff use safe transferring and positioning devices or techniques when assisting residents who require assistance with transfers. Part of the order was to provide education to all direct care staff in regards to different types of transfer methods. The home was to be in compliance by a specific date in February 2017.

Record review of resident #068's most recent written plan of care and kardex dated an identified date, indicated the resident required two staff to provide assistance for manual transfer. The resident required assistance from one staff

for toilet use and personal care.

An interview with staff #196 on an identified date in April 2017, revealed that staff #196 has been assisting resident #068 for transfer from chair to toilet with one person if the resident was able to weight bear and cooperative, and has been assisting resident #068 for transfer from bed to chair and chair to bed with two people. Staff #196 stated that resident #068's kardex indicated the resident required two people to provide assistance for transfer, and one person assistance for toilet use and personal care, and the resident was transferred manually. Staff #196 further stated that his/her understanding was to assist the resident with one person for toilet use, included transferring the resident from chair to toilet, according to the kardex.

Interview with staff #159 revealed that staff #196 did not understand the definition of "transfer", and further stated the definition of transfer was to move a resident from one place to another which was included in the transfer training material. Staff #159 confirmed that staff #196 did not use safe techniques when providing assistance to transfer resident #068.

Interview with staff #159 revealed that transfer training included mechanical and manual transfers. Mechanical transfer training was provided by one of the nurse managers, and the manual transfer training was provided by the physiotherapist. Record review of the Lifts & Transfers Education Inservice for 2016 and 2017 and sign in sheets, and interview with staff #159 revealed that 44 per cent of direct care staff did not receive mechanical and manual transfers training as of the compliance due date of compliance order #003. Record review of the Lifts & Transfers Education Inservice for 2016 and 2017 record indicated staff #196 received mechanical transfer training in April 2016 and manual transfer training on a specific date in March 2017.

The severity is potential for actual harm related to unsafe transferring technique, and the scope is a widespread as 44 per cent of staff did not receive the safe transferring training. The previous compliance history revealed two compliance orders had been served under inspection #2015_324567_0016 and #2016_353589_0016. The compliance date for inspection #2016_353589_0016 was a specific date in February 2017. As a result of this ongoing non-compliance with O. Reg. 79/10, s. 36, a compliance order and a Director Referral is warranted. [s. 36.] (507)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 30, 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 24th day of May, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

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