Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 20, 2017	2017_632502_0016	023111-17	Complaint

Licensee/Titulaire de permis

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

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

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

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

JULIENNE NGONLOGA (502), VERON ASH (535)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 3, 4, 5, and 6, 2017.

The following evidence related to s.5 will be captured under inspection report 2017_630589_0015.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), interim Executive Director (I-ED), interim Director of Care (I-DOC), Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical nurse (RPN), Personal Support Workers (PSW),Registered Dietitian (RD), Nurse Managers (NM), residents, and resident's Substitute Decision Maker (SDM).

During the course of the inspection, the inspector(s) reviewed residents' health records, staffing schedules, staff employment records, training records, home's record and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Nutrition and Hydration
Pain
Personal Support Services
Responsive Behaviours

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident responsive behaviour plan of care

was based on an interdisciplinary assessment of the resident which included mood and behaviour patterns, identified responsive behaviours, and potential behavioural triggers and variations in the resident functioning at different times of the day.

On an identified date, a complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to improper care of resident #008. Review of the complaint revealed that during a care conference held on an identified date, resident #008's family voiced concerns to staff that they had noticed extreme change in resident health condition.

Review of the resident assessment instrument-minimum data set (RAI-MDS) revealed that resident #008 was admitted to the home two months prior to this inspection, was moderately cognitively impaired with poor decision-making skills, and cues and supervision were required. On an identified date, resident #008 was transferred to acute care hospital for assessment and treatment related to a specified responsive behaviours. Record review revealed that from the time of admission to the home, the resident displayed some identified responsive behaviours.

Review of resident #008's most recent written plan of care revealed the resident had identified responsive behaviours; however there were no potential behavioural triggers and variations in the resident functioning at different time of the day present with associated intervention included.

During interviews, staff #197, #108 and #199 confirmed the responsive behaviours described above are to be true and they stated that the behaviours appeared to be more prominent during the evening shift.

During an interview, staff #196 confirmed the above mentioned responsive behaviours; and that the resident was not assessed by the home's internal behavioural support outreach team (BSO) or the external psycho-geriatric outreach program (POP) as the nurse manager assigned to the unit usually follow up with the physician regarding residents responsive behaviours. At the time of the inspection, the resident home unit had a recent turnover in nurse manager, therefore the discussion related to the resident's behaviours and referral support was missed.

During interviews, staff #156 and #122, who is also the BSO lead confirmed that the registered staff on the unit was to complete a behaviour assessment in the home's electronic documentation system which would triggered a referral to the home's

behaviour support program. In addition, the BSO lead stated that registered staff should also discuss resident #008's responsive behaviours with the physician and obtain an order for a referral to external resources such as the POP team, and also contact the family to obtain consent for the referral. Staff #122 further confirmed that the resident should have been referred to the home's BSO and POP team so that the behaviour patterns, triggers, and variations in resident #008 functioning at different times of the day could be assessed and appropriate interventions set in place to support the resident's behaviours. [s. 26. (3) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident responsive behavior plan of care was based on an interdisciplinary assessment of the resident which included mood and behavior patterns, identified responsive behaviors, and potential behavioral triggers and variations in the resident functioning at different times of the day, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

On an identified date, a complaint was submitted to the MOHLTC related to improper care. Review of the complaint revealed that resident #008's substitute decision maker

(SDM) reported that he/she requested the shower dates and times be changed to accommodate a morning shower on Wednesdays and Sundays. Although the family made the request, the SDM stated that he/she noticed resident #008 appeared to be un-kept during the family's visits.

Review of the personal support workers' electronic documentation in point of care (POC) under completed tasks revealed resident #008 was bathed on two occasion after admission in the home. Further review revealed that baths had not been included on the personal support service daily assignment in POC since the last bath, which was a period of 42 days before the resident being transferred to the hospital.

Review of care conference notes held on an identified date, revealed the family requested that resident #008 weekly showers be changed from Tuesday and Saturday evening to Wednesday and Sunday morning.

In an interview, staff #198 stated he/she was the primary caregiver for resident #008 during the evening shift. Staff #198 further stated that resident #008's shower days and time had been changed from evening shower to day shower 42 days prior to resident #008's transfer to the hospital; therefore, she /she had not given resident #008 a shower since the change.

In an interview, staff #197 stated that he/she was the primary caregiver for resident #008 during the morning shift. Staff #197 further stated that he/she had not given resident #008 a shower, as he/she believed resident #008 was scheduled for evening shower.

In an interview staff #196 stated that resident #008 was given a shower the first week after his/her admission in the home. Staff #196 further stated that he/she was advised that resident #008's bath time had changed from evening to day following the family request. Staff #196 confirmed that resident #008 had not been bathed for a period of 42 days, when he/she was transferred to the hospital, as resident #008 shower days and time were not identified on the PSWs assignments in POC . [s. 33. (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 the resident is bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

Issued on this 6th day of November, 2017

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

Original report signed by the inspector.