Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 13, 2018	2018_324535_0002	001509-18	Complaint

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM 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

VERON ASH (535), JULIENNE NGONLOGA (502)

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): January 29, 30, 31, February 1, 2, 2018.

Findings identified in this inspection report was also supported by previous evidence and interviews collected during inspection #2017_632502_0016, issued on October 20, 2017.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Nurse Manager, Director of Dietary Services, Resident Relations Coordinator, registered staff RN/ RPN, personal support worker (PSW), and resident.

During the course of the inspection, the inspector made relevant observations, and record reviews of health records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

On an identified date, resident #001's substitute decision-maker (SDM) reported to the ministry of health (MOH) that resident #001 was assaulted by being punched by another resident, which was not reported to the SDM.

Record review of emails provided by the home revealed that on an identified date, resident #001's substitute decision maker (SDM) sent an email to the home's social worker #101 to inform that during a recent visit to the home, the resident told them that while they were coming out of their room and going to the dining room for the meal on an identified date, another resident had hit them without being provoked. The SDM expressed their concern in the email that they were not notified of the incident by the nursing team on duty that shift.

A review of the progress notes revealed and staff interview with PSW #119 confirmed that on an identified date, resident #002 was sitting in the wheelchair which was in the direct pathway of access to the dining room, and when resident #001 was being taken into the dining room for seating, resident #002 reached out with the hand and hit resident #001 on the identified area of the body. PSW #119 reported the incident to registered staff RPN #108, who assessed resident #001 and documented no sign or symptom such as redness, bruise, or other injury; and resident #001 denied experiencing pain or discomfort in the area, and then proceeded to complete the meal. The registered staff followed up related to the incident; and informed the on-call physician who prescribed a medication to be administered to resident #002 and dementia observation system (DOS) monitoring commenced for that resident; however no treatment was required for resident #001 as there was no injury sustained or signs of distress noted as a result of the incident.

In an interview, registered staff RPN #108 confirmed that resident #001 completed the meal; then sat calmly outside their room door in front of the nursing station for the rest of the shift before settling to bed. The RPN further stated they could not recall reporting the incident to the family during the shift. During the scheduled care conference on an identified date, the interdisciplinary team discussed the reported SDM's concerns including this incident, and the PSW and registered staff involved apologized to the family for not reporting the incident.

In an interview, Social Work #101 and the previous Executive Director #115 confirmed the incident was not reported to the SDM; and that the incident should have been reported. [s. 97. (1) (a)]

2. The licensee has failed to ensure that the resident and the resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

On an identified date, a complainant reported to the MOHLTC that resident #001 sustained multiple assaults while residing in the home.

a) A review of the progress notes revealed and staff interview with PSW #119 confirmed that on an identified date, resident #002 was sitting in the wheelchair which was in the direct pathway of access to the dining room, when resident #001 was being taken into the dining room for seating, resident #002 reached out and hit resident #001 on an identified area of the body. PSW #119 reported the incident to registered staff RPN

#108, who assessed the resident and documented no injury; and resident #001 denied experiencing pain or discomfort in the area, and then proceeded to complete the meal. The registered staff followed up related to the incident; however resident #001 did not require further treatment as there was no injury or noted distress caused by the incident. Nurse Manager #104 was informed of the incident and conducted an investigation; and during the scheduled care conference on an identified date, the incident was discussed by the interdisciplinary team and interventions set in place as agreed by the family and the team.

b) On an identified date, registered staff RPN #108 documented that resident #001 was yelling inside the room; and as the resident exited the room, they told the registered staff that resident #002 had hit them on an identified area of the body. The incident was not witnessed by a staff; however, registered staff RPN #108 conducted an assessment of the area and documented no injury found to the area; and that the resident denied pain or discomfort. The incident was reported to the SDM; both residents were separated and monitored; and resident #001 sat calmly in front of the nursing station in their usual position for the rest of the shift. In an interview, the registered staff stated that they reported the incident to the nurse manager for follow up. In an interview, the social worker #101 stated that they became involved during the investigation; and offered to relocate resident #001 to another room; however the family declined the offer; therefore, resident #002 was relocated to another room with their SDM consent.

c) Record review revealed and staff interview confirmed that resident #001 was observed by the PSW to have an alteration in skin integrity. On an identified date, the PSW providing care reported to registered staff RPN #109 that the resident had an alteration in skin integrity. The registered staff stated that during their assessment and follow up, the resident was asked what caused the alteration in skin integrity and they replied that it was old from some time ago; however the PSW informed the registered staff they had not seen the alteration in skin integrity before. The registered staff assessed and documented the alteration in skin integrity on the weekly skin assessment tool, informed the registered dietitian, physician, and informed the SDM. In the interview, the registered staff stated that the family was thankful for the call and had no voiced concerns. During the interview, registered staff #109 was asked about the cause of the unknown alteration in skin integrity; and responded that it could be related to the specified care activities that the resident did without asking for assistance from staff. In separate interviews, RPN #109, RPN #111, PSW #119, PT #107 and resident #003 all confirmed that the resident was reminded and encouraged to call for assistance.

During interviews, DOC #100, Nurse Manager #102, and Social Worker #101 confirmed these and other incidents were reported to the home by the family; however some of the incidents reported were not supported by documentation or staff interviews; and therefore could not be substantiated during an internal investigation. DOC #100 confirmed that the incidents of alleged assault reported to the home were considered resident to resident altercation as referenced by the home's abuse policy and the MOH abuse decision tree. The DOC further acknowledged that the follow up investigations conducted by the previous Nurse Manager #104, who no longer worked in the home, could not be located; and therefore, the home could not confirm that the resident's SDMs were notified of the results of all alleged assault investigations immediately upon their completion. [s. 97. (2)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that includes: the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response, and; any response made by the complainant.

On an identified date, a complainant reported to the MOHLTC that they had sent multiple email communication to the management team related to the care of resident #001 in the home.

A review of those emails on specific dates sent to the home revealed the following concerns were raised (a) missing of a water bottle, (b) resident being in a specified health state, and (c) assistance with meal and resident being denied food.

A review of the progress notes copied from the home's electronic documentation system revealed the following:
- On the first specified date, an Interdisciplinary Care Conference with resident's family in attendance was held to address the resident's POA concern.
- On the second specified date, the resident reported to staff about the missing water bottle. Staff searched in the unit dining room and resident's room but water bottle was not found. Missing article form posted at the nursing station.
-On the third specified date, the resident's SDM reported to staff about the missing water bottle.
-On the fourth specified date, NM documented that they had filled out missing article report form regarding water bottle, and directed staff to keep an eye out.
-On the fifth specified date, the home dietitian responded to a diet referral and follow up with the resident's POA on the same day.

In an interview, the previous NM #104 stated that the above concerns identified were investigated and documented, and the documentation was provided to the home safe on a USB key prior to leaving the employment of the home.

In an interview, DOC # 100 stated that they were not able to locate the documentation left by the previous NM #104; and acknowledged that a documented record of these incidents had not been kept in the home. [s. 101. (2)]

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Issued on this 15th day of February, 2018

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

Original report signed by the inspector.