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 5, 2018	2017_324535_0023	025091-17, 025093-17, 025095-17, 026402-17, 026405-17, 026406-17, 026408-17, 028114-17	Follow up

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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): December 7, 8, 11, 12, 13, 14, 15, 2017.

Findings of non-compliance related to LTCH Act, 2007, s. 5, s. 6 (4) (a), and s. 6 (7), identified in inspection report #2017_632502_0022, will be issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Nurse Manager, Director of Dietary Services, Director of Environmental Services, Director of Resident Programs, Resident Relations Coordinator, Resident Assessment Instrument (RAI) Coordinator, registered staff RN/ RPN, personal support worker (PSW), maintenance worker, housekeeping staff, Substitute Decision Makers (SDMs), and residents.

During the course of the inspection, the inspector made observations related to staff to resident interactions and provision of care; conducted reviews of health records, staff education and training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Infection Prevention and Control
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
5 WN(s)
0 VPC(s)
4 CO(s)
1 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. 15. (2)	CO #002	2017_324535_0014	535
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2017_632502_0014	535
O.Reg 79/10 s. 20. (2)	CO #003	2017_324535_0014	535
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #003	2017_630589_0015	535

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. 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 used safe transferring and positioning devices or techniques when assisting resident #003.

The licensee failed to comply with compliance order and Director's Referral #001 from inspection #2017_324535_0014 served on October 27, 2017, with a compliance date of

November 3, 2017. The licensee was ordered to:

1. Develop and implement a plan to ensure staff use safe transferring and positioning devices or techniques when assisting residents.
2. Develop and implement a policy or procedure (or include in current weight monitoring policy) to ensure monthly reassessment of residents exhibiting significant weight changes and who were assessed by the physiotherapist to require a mechanical lift for transfer; to ensure the size of sling and type of mechanical lift are appropriate for safe transfers.
3. Develop and implement a plan to ensure all direct care staff become familiar with the difference in use and application of the high back sling and the hygienic sling used in the home.
4. Develop and implement quality improvement initiatives such as audits to ensure the policy/procedure related to monthly reassessment of residents exhibiting significant weight changes and assessed by the physiotherapist to use a mechanical lifts, is effectively implemented.

The home successfully completed items # 2, #3, and #4 as ordered; but failed to complete item #1 - to effectively implement the plan to ensure staff used safe transferring and positioning devices or techniques when assisting residents at the time the inspectors re-entered the home to inspect this order on December 7, 2017, as demonstrated by the evidence included in this report.

Record review of the home's minimum data set (MDS) assessment on an identified date revealed an assessment of resident #003 cognition. Resident #003 required the support of two staff for transferring and continence care. Record review of the resident plan of care revealed the same information; and that the resident was to be toileted in bed using a specified lift and sling.

On an identified date, inspector #502 observed resident #003 being transferred by PSW #117 and #122 in a location other than the resident's room. The resident was transferred using another identified lift and sling in the other location in the home. The inspector observed that the resident was not holding on to support self during the transfer and that the resident's feet were not touching the base of the other lift that was used to transfer the resident.

During an interview, PSW #122 confirmed that they were the primary caregiver; was aware of the specified lift and sling to be used to transfer this resident; and was aware

the resident was to be changed in the room instead of the other location. However, the PSW stated that they had a heavy work assignment with multiple demanding residents to provide care for during the shift and that they wanted to provide care to the resident in this location.

During an interview, PSW #117 confirmed the incident occurred as recorded above; and stated that they normally worked on another unit and was unfamiliar with the resident, but did not have an opportunity to check the care plan prior to helping with the transfer. PSW #117 stated that they became aware that a specific lift and sling were required for the resident after PSW #122 answered the questions asked by the inspector during the transfer.

During an interview, DOC #102 stated that the resident required the specified lift and sling for transferring and should have been provided care in the room; and that PSWs used unsafe transferring and positioning devices and techniques while assisting resident #003.

The severity of this issue was determined to be actual harm/risk to the resident. The scope of this issue was a isolated as it related to one resident. The home had multiple ongoing non-compliance including compliance orders and a previous Director Referral with this section of the LTCHA which included:
- Director Referral #2017_324535_0014 issued October 27, 2017;
- Director Referral #2017_644507_0003 issued on March 7, 2017;
- Compliance Order #2016_353589_0016 issued on August 3, 2016;
- Compliance Order #2015_324567_0016 issued on November 30, 2015. [s. 36.]

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 LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for resident #002.

On an identified date, a critical incident system report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) about an incident of self-harm with the use of a sharp item by resident #002.

The licensee failed to comply with compliance order #001 from inspection #2017_324535_0014 served on October 27, 2017, with a compliance date of November 30, 2017. The licensee was ordered to:

1. Develop and implement a process to ensure that staff, visitors, contractors and vendors are made aware of the importance of securing doors in the home which lead to non-residential areas to prevent residents from accessing those area.
2. Conduct assessments to ensure that residents who wish to use the stairwells can do so unsupervised in a safe manner.
3. Develop a plan to ensure all sharp items and instruments are disposed of immediately after use; and stored safely and securely in an area not accessible to residents.
4. Conduct assessments to ensure that residents who wish to use sharp items or sharp instruments can do so unsupervised in a safe manner.
5. Develop quality improvement initiatives such as audits to ensure doors that are accessible to non-residential areas are kept closed when not in use or properly supervised; and an audit system to ensure sharp items and instruments are stored in a safe and secure location in the home.

The home successfully completed items #2, #4 and #5; however, failed to implement items #1 and #3 - the home did not provide a safe and secure environment for resident #002 related to staff communicating the access code for door leading to non-resident area which allowed resident #002 to gain access to sharp items that were left unsecured in a specific room. The home's safety plan was to complete an audit of residents utilizing sharp items and ensure those residents had access to alternatives. This action was not completed at the time inspectors re-entered the home to inspect the order on December 7, 2017, as demonstrated by the evidence included in this report.

a) According to an identified CIS, resident #002 consumed an identified amount of medications that belong to another resident. The home assigned one-on-one staff to closely monitor resident #002, as a consult note indicated that resident #002 was likely to engage in some form of self-harm.

b) A review of another identified CIS revealed that PSW #108, who was assigned to closely monitor resident #002 on one-on-one (1:1), reported that the resident gained access and removed sharp items from a specific room which should have remained locked. Further review of the CIS revealed that registered nursing staff retrieved one of the sharp item before the resident exited the facility with the remaining sharp items in their possession. The CIS also stated that at a later time, resident #002 returned to the home and gained access to the specific room when the door was opened and while staff were removing another resident. While inside that room, the resident had access to sharp items and proceeded to inflict harm to identified areas of their body. The resident was transferred to the acute care hospital for assessment and treatment. On another identified date, sharp items were observed in the specific rooms on multiple floors in the home. And, on that same date, the inspector observed PSW #124 yelling the access code aloud in the hallway.

During an interview, resident #002 stated that they had experienced a condition which they believed could have been relieved by using those sharp items. Resident #002 stated that when they entered the specific room there were multiple sharp items left unattended. The resident told the inspector that they were aware that staff stored the sharp items in that specific room; and that they knew the access code to that room. The resident told the inspector the access code which was confirmed to be correct.

During an interview, PSW #108, who was assigned to provide 1:1 supervision, stated that they observed resident #002 indicating they had a condition; and confirmed that resident #002 told them that during a specific temperature, they experienced the condition; however, the PSW did not share that information with the registered staff. PSW #108 stated that they observed the resident taking sharp items from the shower room and reported the incident to the registered staff as the PSW was not able to approach the resident.

During an interview, RPN #124 stated that they were called by PSW #108 and told that resident #002 had taken sharp items from the specific room. RPN #124 stated that they approached the resident and managed to retrieve one sharp item, and then called the charge nurse RN #125 as resident refused to give up the other sharp items prior to

exiting the home.

During an interview RN #125 stated while talking to the RPN and PSW on the unit, the resident returned to the unit and entered the access code to the specific room, went inside and blocked the entrance; then proceeded to cause self-inflict harm to identified areas of the body. RN #125 stated that this incident was a result of neglect as sharp items should not be left anywhere or in any part of the home, and staff should have disposed of sharp objects after use. RN #125 also stated that staff did not want to get close to the resident while providing 1:1 supervision.

In an interview, DOC #101 acknowledged that the staff had not followed the safety procedures put in place to protect resident #002 from self-harm. [s. 5.]

2. On an identified date, the inspector observed that the main dining room doors which separated the resident's main dining room from the non-residential area close to the back elevator, were unlocked and opened with cold air blowing into the dining room directly from outside the building. During the period of time that the door was opened, there was a faint sound of an alarm heard in the vicinity of the doors. The inspector observed that there was a delivery truck at the back exit door of the building unloading supplies for the home; and the back door was propped opened.

During this observation, resident #032 was still sitting in the dining room. The resident's table was directly across from the opened door; therefore they were calling out for someone to close the dining room doors because the air blowing into the room was cold and directly from outside. The inspector requested the assistance of dietary staff #133; and the doors were forced-shut to secure the dining room against the blowing wind.

During an interview, the home's Director of Environmental Services (DES) #112 stated that they were made aware that the magnetic locks for the dining room doors, which led to a non-residential area and access to the back exit, were not closing entirely on the previous day; and that they had noticed that the magnetic locks on that main dining room door were weakened and would sometimes become disengaged whenever the back door was open for delivery. The DES also confirmed that there should have been an alarm sounding whenever the door was left open for an extended period of time; however they were not aware that the alarm was turned down to a minimal volume.

The inspector observed that the DES left the building shortly after the conversation; and they confirmed that they were going out to purchase supplies to repair the dining room

doors. In the interim however, the inspector observed, and this information was confirmed by the Director of Dietary Program #131, that there were no signage posted or personnel in place beside the dining room doors to alert staff and residents that the magnet locks were non-functional.

During an interview, DOC #102 was made aware of the incident; and they informed the inspector that the doors should be monitored in the interim until the locks were repaired. The DOC placed a student to monitor the dining room doors until the magnetic locks could be repaired or replaced by the DES. The inspector observed two maintenance workers replacing the magnetic locks on the dining room doors in the afternoon; and the doors were being monitored by the student. [s. 5.]

3. On an identified date, the inspector observed the following sharp items left unattended while performing follow up inspection observations in the home:

In a first identified location, the inspector observed two sharp items were left unattended. During an interview, PSW #121 stated that the sharp items should have been disposed of in the sharp container after use. The PSW removed and disposed of the sharp items in the sharp container.

In a second identified location, the inspector observed sharp items left unattended. During an interview, PSW #119 and registered staff RN #118 informed the inspector that the sharp items should have been disposed of into the sharp container.

In a third location, the inspector observed sharp items left unattended. During an interview, PSW #115 stated the used sharp items should have been disposed in the sharp container, and they disposed of the sharp item in the sharp container. During an interview, PSW #117 and Nurse Manager #116 confirmed that the used sharps should have been disposed of in the sharp container. PSW #117 disposed of the used sharp items in the sharp container.

In a fourth location, the inspector observed sharp items left unattended. During an interview, PSW #113 and registered staff RPN #114 stated that used sharp items should have been disposed of in the sharp container. PSW # 113 disposed of the sharp items in the sharp container.

During an interview, DOC #101 and #102 stated that the expectation was for direct care staff to dispose of all used sharp items in the sharp container immediately after use.

The severity of this issue was determined to be actual harm/risk to the resident. The scope of this issue was patterned as it was related to more than one resident. The home had ongoing history of non-compliance including a previous compliance order with this section of the LTCHA during inspection # 2017_324535_0014 issued on October 27, 2017. [s. 5.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

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

On an identified date, the inspector conducted health record reviews related to resident #006 during a follow up inspection.

The licensee has failed to comply with compliance order #001 from inspection

#2017_630589_0015 served on October 20, 2017, with a compliance date of November 17, 2017. The licensee was ordered to:

1) Develop and implement a process to ensure collaboration occurs among the interdisciplinary team.
2) The home shall also include scheduled meetings which will allow direct care staff opportunities to collaborate in the development and implementation of the plan of care.
3) Continue to schedule and conduct management and direct care staff meetings that allow for such collaboration with each other in the development and implementation of the plan of care.

The home successfully completed items #2 and #3 as ordered; however failed to effectively implement item #1, the process to ensure collaboration amongst the interdisciplinary team as stated in their action plan, at the time inspectors re-entered the home to inspect the order on December 7, 2017; and as demonstrated by the evidence included in this report.

Record review of the home's minimum data set assessment revealed that resident #006 had an assessment completed which yield information related to mobility, transfer and locomotion abilities of the resident.

Record review of the progress notes revealed that on an identified date, the resident was assessed by physiotherapist # 126 related to safe ambulation. On another identified date, the progress notes revealed that the primary physician documented pertinent information related to the resident's ambulation ability; and documented their medical recommendations related to safety concerns in the electronic documentation system.

Record review of the residents MDS assessment and plan of care revealed that a health condition was not included in the resident's plan of care although the resident was prescribed and administered medication to control the condition.

During separate interviews, primary PSW #106, registered staff RPN #104 and the unit Nurse Manager #103, all confirmed that they were unaware the resident was had the condition; and RPN #104 and Nurse Manager #103 were not aware that the physician had documented the statement related to the safety concerns for the resident because of this condition while ambulating.

During an interview, DOC #102 stated that the physician documented pertinent

information in the progress notes which should have been shared with the interdisciplinary team; however the information was not captured in the 24 hour reporting form printed and reviewed daily; and therefore the information was missed and not shared with the interdisciplinary team. The DOC also stated that they thought all physicians documentation in their electronic documentation system were captured consistently on the 24 hours report; and that they would follow up with their head office information technology department to check if physician documentation could be captured in the 24 hours report so that they were not missed in the future. [s. 6. (4) (a)]

2. On an identified date, the inspector conducted a responsive behavioral record review related to resident #037 during the follow up inspection.

Record review of the home’s minimum data set (MDS) assessment revealed resident #037 had displayed responsive behaviors.

A review of compliance order (CO) #002 issued during Inspection # 2017_630589_0015, dated October 20, 2017, revealed that the home was issued a compliance order related to resident #037's plan of care. Record review of the progress notes revealed that the home's internal behavior support (BSO) team assessed the resident and a progress note was written by the BSO lead on an identified date related to interventions and strategies to put in place to support the resident's responsive behaviors. The home submitted an action plan to the MOH with corrective actions to follow up with and incorporate these BSO interventions within the resident plan of care by November 30, 2017.

The inspector interviewed DOC #101 and #102 regarding resident #037 and the home’s action plan related to the previous finding issued by the MOHLTC. The inspector was informed by both DOCs that BSO interventions were not implemented because the team was unaware of the progress notes written by the previous BSO lead who was no longer working in the home; and therefore, the interdisciplinary team was not made aware of the listed BSO interventions; and this information was not followed up by the most responsible team members.

During the interview, both DOCs acknowledged that staff and others involved in the different aspects of resident #037 care should have collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

3. On an identified date, the inspector conducted a responsive behavioral record review

related to resident #038 during the follow up inspection.

Record review of the home's minimum data set (MDS) assessment revealed resident #038 had displayed responsive behaviors.

A review of compliance order (CO) #002 issued during Inspection # 2017_630589_0015, dated October 20, 2017, revealed that the home was issued a compliance order related to resident #038's plan of care. The compliance order was due to be complied on November 30, 2017, related to a resident to resident altercation that occurred when resident #038 entered into resident #037's room. Record review and staff interview with DOC #102 revealed that the physician was not made aware of resident #038's responsive behaviors until a later date, after the inspector approached the team during the follow up inspection. A review of the progress notes revealed that on the date the resident was assessed by the physician, the resident was prescribed medication to treat their responsive behaviors; and on another identified date, the resident was referred to the home's BSO team by DOC #102 for assessment and implementation of interventions related to the resident's responsive behaviors.

On an identified date, the inspector interviewed DOC #101 and #102 related to the previous finding issued by the MOHLTC. DOC #102 confirmed that resident #038's responsive behaviors were not communicated to the physician and the home's BSO team prior to the inspector's re-entry into the home. The DOC further stated that the registered staff should have completed a behavioral referral assessment in point click care which would have triggered contact with the physician and the BSO team; and possibly a referral to the psycho-geriatric outreach program (POP) related to the resident's responsive behaviors.

4. On an identified date, a critical incident system report (CIS) was submitted to the MOHLTC regarding an incident of self-harm with a sharp items by resident #002.

Review of DOS monitoring revealed that on an identified date, resident #002 was monitored closely by a 1:1 PSW. Further review of the DOS documentation failed to reveal any change in condition.

Review of resident #002's written plan of care on a specified date, revealed the resident's history and diagnosis.

In an Interview, resident #002 told the inspector that they had experienced an condition

prior to the incident of self-harm, and that they had told the 1:1 PSW assigned to them about the condition. The resident further stated that they did not tell registered staff about the condition they had experienced because they believed the registered staff did not have any prescribed medication on file to relieve the condition.

In an interview, PSW #108 stated that they observed resident #002 during the condition, and confirmed that the resident told them about it. PSW #108 confirmed that when they returned to the unit, the resident became engaged in a responsive behaviors toward the registered staff; and they did not inform the registered staff about the resident's condition; and did not document the condition on the DOS documentation.

In an Interview, RPN #124 and RN #125 stated that they were not aware that resident #002 had experienced the condition while they were with the 1:1 PSW off the unit. Both registered staff also stated that they did not ask the 1:1 PSW if an event had occurred with the resident prior to the responsive behavior incident when the resident returned to the unit.

In an Interview, DOC #102 acknowledged that PSW #108, who was assigned to provide 1:1 supervision should have documented the observation and informed the registered staff about the resident's condition when they returned to the unit.

The severity of this issue was determined to be actual harm/risk to the resident. The scope of this issue was patterned as it was related to four residents. The home had ongoing history of non-compliance including a previous compliance order with this section of the LTCHA during inspection #2017_630589_0015 issued on October 20, 2017. [s. 6. (4) (a)]

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

On an identified date, a critical incident system report (CIS) was submitted to the ministry of health and long-term care (MOHLTC) about an incident of self-harm with a sharp item by resident #002.

The licensee failed to comply with compliance order #002 from inspection #2017_630589_0015 served on October 20, 2017, with a compliance date of November 17, 2017. The licensee was ordered to prepare, submit and implement a plan to ensure

that care was provided to residents as specified in the plan of care.

The home failed to effectively implement the plan to ensure that care was provided to residents as specified in the plan of care; and implementation of the plan was not completed at the time inspectors re-entered the home to inspect the order on December 7, 2017, as demonstrated by the evidence included in this report.

a) Review of the CIS revealed that resident #002 had obtained a sharp item and caused self-inflict harm for which they were transferred to acute care hospital for further assessment and treatment. The CIS further indicated that the home was in the process of obtaining staff to provide one-on-one (1:1) supervision for the resident.

A review of the RAI-MDS assessment was completed related to resident #002.

b) A review of resident #002’s written plan of care revealed that resident #002’s had a history of self-inflict harm. Further review of the written plan of care revealed a request that a staff of an identified gender should not be involved in the resident’s care; however a review of the schedule for 1:1 monitoring staff over an identified period of time revealed that a staff of an identified gender was assigned to closely monitor resident #002 on two listed dates.

Review of resident #002 progress notes revealed that RPN # 124 documented that resident #002 told a PSW assigned to provide 1:1 supervision, that they did not want a staff of an identified gender to provide support or care.

In an interview, identified staff #130 confirmed that they had provided 1:1 close supervision for the resident on the two specified dates; and that their responsibility was to prevent the resident from exhibiting responsive behavior that included self-harm.

In an interview, PSW #122 stated that on one of the scheduled date when the resident had an identified gender specific staff for monitoring, resident #002 refused personal care, as the resident believed that the staff assigned would follow and monitor them while personal care was being performed by the direct care staff.

During an interview, resident #002 stated that after ED #100 told them that the identified gender specific staff would be assigned to provide 1:1 close monitoring, the resident requested that they do not have the identified staff provide monitoring.

During an interview, DOC #101 acknowledged that 1:1 monitoring and DOS monitoring were part of responsive behavior management, and that the identified staff should not have been assigned to resident #002. DOC #101 stated that the identified staff was assigned to resident #002 as a last resort, as there was not enough home staff available to provide coverage; and the agency did not have the required staff available to provide monitoring.

During an interview, ED #100 stated that they were advised by the local health integration network (LHIN) to have a one to one staff assign to resident #002 as the resident had a history of self-harm. ED #100 further stated that the agency did not have a required staff available, as a result they did not have a choice but to assign the identified available staff to supervise the the resident. [s. 6. (7)]

6. On an identified date, inspector #502 observed that resident #002 was to be assisted to the bathroom and post care provided by PSW #122 alone. Record review of the resident plan of care revealed that due to responsive behaviors, the resident required two staff to be present during personal care; and the resident was to be assisted to the bathroom with two staff assistance.

During an interview, PSW #122 stated that they were aware the resident required two staff to be present during personal care; however, the PSW stated that the resident trusted the PSW and did not like having agency staff present; therefore personal care was performed with one staff assistance.

During an interview, DOC #102 stated that personal care should have been performed with two staff present; therefore the PSW did not provide care to the resident as specified in the resident plan of care.

The severity of this issue was determined to be actual harm/risk to the resident. The scope of this issue was isolated as it was related to one resident. The home had ongoing history of non-compliance including a previous compliance order with this section of the LTCHA during inspection #2017_630589_0015 issued on October 20, 2017. [s. 6. (7)]

Additional Required Actions:

CO # - 003, 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways and to the outside of the home were kept closed and locked.

On an identified date, the inspector observed a staff member who exited the back door of the home, propped open the door with a piece of wood, entered a car parked outside in the rear parking lot, and drove out of the parking lot. The staff member left the area rather quickly and the inspector was not able to identify or speak with the staff involved in this incident. During an interview, the home's Director of Environmental Services #112 stated that staff members should not be propping the rear exit door open and leaving the area unattended. [s. 9. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #031 restraint monitoring documentation included all assessment, reassessment and monitoring, including the resident's response.

On an identified date, the inspector conducted a restraint record review related to resident #031 during a follow up inspection.

Record review of the home's minimum data set (MDS) assessment revealed that resident #031 used a form of restraint. Record review of the resident plan of care revealed that staff was to check the resident every two hours; and residents with restraint were to be monitored and documented every one hour.

A review of the documentation related to the restraint monitoring record revealed that the physician ordered the use of a specified restraint for the resident; the restraint monitoring records which included the documentation of hourly assessment and monitoring of the resident's reactions were not completed by the PSW or registered staff on multiple dates and during various shifts.

At the time of this review, the inspector was not able to locate the restraint monitoring documentation for one entire month.

During an interview, PSW #105 confirmed that they did not complete the documentation related to the restraint monitoring record from the previous day shift; and had not completed the record for the current shift up to and including the time of the interview. PSW #105 stated that they were away from the home for an extended period and had just returned to work in the previous month. The PSW initially informed the inspector that the resident's restraint monitoring was recorded on the dementia observation system (DOS) form; however after a discussion with the registered staff RPN #104 and requesting the location of the restraint monitoring records, the PSW found the appropriate binder with the actual restraint monitoring record forms to be completed.

During an interview, registered staff RPN #104 and Nurse Manager #103 reviewed the restraint monitoring records for the three month period; and informed the inspector that documentation on the restraint monitoring record form should have been consistently completed at least every hour by the assigned PSWs and registered staff for all applicable shifts since the initiation of the restraint used by the resident. [s. 110. (7) 6.]

Issued on this 13th day of February, 2018

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

Original report signed by the inspector.

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) :	VERON ASH (535)
Inspection No. / No de l'inspection :	2017_324535_0023
Log No. / No de registre :	025091-17, 025093-17, 025095-17, 026402-17, 026405-17, 026406-17, 026408-17, 028114-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Feb 5, 2018
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Midland Gardens Care Community 130 Midland Avenue, SCARBOROUGH, ON, M1N-4B2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Debbie Fleming

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: 2017_324535_0014, CO #004;

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 must be compliant with s.36. Specifically, the licensee will ensure staff use safe transferring and positioning devices or techniques when assisting resident #003; and any other resident requiring transfer with a mechanical lifting device.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #003.

The licensee failed to comply with compliance order and Director's Referral #001 from inspection #2017_324535_0014 served on October 27, 2017, with a compliance date of November 3, 2017. The licensee was ordered to:

1. Develop and implement a plan to ensure staff use safe transferring and positioning devices or techniques when assisting residents.
2. Develop and implement a policy or procedure (or include in current weight monitoring policy) to ensure monthly reassessment of residents exhibiting significant weight changes and who were assessed by the physiotherapist to require a mechanical lift for transfer; to ensure the size of sling and type of mechanical lift are appropriate for safe transfers.
3. Develop and implement a plan to ensure all direct care staff become familiar with the difference in use and application of the high back sling and the hygienic sling used in the home.
4. Develop and implement quality improvement initiatives such as audits to ensure the policy/procedure related to monthly reassessment of residents

exhibiting significant weight changes and assessed by the physiotherapist to use a mechanical lifts, is effectively implemented.

The home successfully completed items # 2, #3, and #4 as ordered; but failed to complete item #1 - to effectively implement the plan to ensure staff used safe transferring and positioning devices or techniques when assisting residents at the time the inspectors re-entered the home to inspect this order on December 7, 2017, as demonstrated by the evidence included in this report.

Record review of the home's minimum data set (MDS) assessment on an identified date revealed an assessment of resident #003 cognition. Resident #003 required the support of two staff for transferring and continence care. Record review of the resident plan of care revealed the same information; and that the resident was to be toileted in bed using a specified lift and sling.

On an identified date, inspector #502 observed resident #003 being transferred by PSW #117 and #122 in a location other than the resident's room. The resident was transferred using another identified lift and sling in the other location in the home. The inspector observed that the resident was not holding on to support self during the transfer and that the resident's feet were not touching the base of the other lift that was used to transfer the resident.

During an interview, PSW #122 confirmed that they were the primary caregiver; was aware of the specified lift and sling to be used to transfer this resident; and was aware the resident was to be changed in the room instead of the other location. However, the PSW stated that they had a heavy work assignment with multiple demanding residents to provide care for during the shift and that they wanted to provide care to the resident in this location.

During an interview, PSW #117 confirmed the incident occurred as recorded above; and stated that they normally worked on another unit and was unfamiliar with the resident, but did not have an opportunity to check the care plan prior to helping with the transfer. PSW #117 stated that they became aware that a specific lift and sling were required for the resident after PSW #122 answered the questions asked by the inspector during the transfer.

During an interview, DOC #102 stated that the resident required the specified lift and sling for transferring and should have been provided care in the room; and that PSWs used unsafe transferring and positioning devices and techniques

while assisting resident #003.

The severity of this issue was determined to be actual harm/risk to the resident. The scope of this issue was isolated as it related to one resident. The home had multiple ongoing non-compliance including compliance orders and a previous Director Referral with this section of the LTCHA which included:
- Director Referral #2017_324535_0014 issued October 27, 2017;
- Director Referral #2017_644507_0003 issued on March 7, 2017;
- Compliance Order #2016_353589_0016 issued on August 3, 2016;
- Compliance Order #2015_324567_0016 issued on November 30, 2015. (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 23, 2018

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2017_324535_0014, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must be compliant with s.5. Specifically, the licensee shall prepare, submit and implement a compliance plan outlining how the licensee will ensure that the home is a safe and secure environment for its residents.

The compliance plan shall include but is not limited to:

1. Developing and implementing a plan to ensure sharp items and sharp instruments are stored securely and disposed of in a sharp containers in the home.

2. Developing a process to ensure that doors leading to non-residential areas of the home are not propped open and left unattended or unsupervised by staff.

3. Creating a monitoring system to ensure staff cease the practice of sharing access codes with each other and visitors to the home, in the presence of any resident; and recreate new access codes with a format that is unfamiliar to residents.

4. Developing and implementing an on-going auditing process to ensure that sharp objects used by the home are monitored, doors are not propped open without supervision, and access codes are not shared. Include the frequency of audits, who will be responsible for doing the audits and evaluating the results.

For the above, as well as for any other elements included in the plan, please include who will be responsible, as well as a timeline for achieving compliance, for each objective/goal listed in the plan.

The plan shall be submitted to the Long Term Care Home Inspector:
Veron Ash by Friday, February 9, 2018 via email to:
veron.ash@ontario.ca

Grounds / Motifs :

1. The licensee has failed to ensure that the home was a safe and secure environment for resident #002.

On an identified date, a critical incident system report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) about an incident of self-harm with the use of a sharp item by resident #002.

The licensee failed to comply with compliance order #001 from inspection #2017_324535_0014 served on October 27, 2017, with a compliance date of November 30, 2017. The licensee was ordered to:

1. Develop and implement a process to ensure that staff, visitors, contractors and vendors are made aware of the importance of securing doors in the home which lead to non-residential areas to prevent residents from accessing those area.
2. Conduct assessments to ensure that residents who wish to use the stairwells can do so unsupervised in a safe manner.
3. Develop a plan to ensure all sharp items and instruments are disposed of immediately after use; and stored safely and securely in an area not accessible to residents.
4. Conduct assessments to ensure that residents who wish to use sharp items or sharp instruments can do so unsupervised in a safe manner.
5. Develop quality improvement initiatives such as audits to ensure doors that are accessible to non-residential areas are kept closed when not in use or properly supervised; and an audit system to ensure sharp items and instruments are stored in a safe and secure location in the home.

The home successfully completed items #2, #4 and #5; however, failed to implement items #1 and #3 - the home did not provide a safe and secure environment for resident #002 related to staff communicating the access code for door leading to non-resident area which allowed resident #002 to gain access to sharp items that were left unsecured in a specific room. The home's safety plan was to complete an audit of residents utilizing sharp items and ensure those residents had access to alternatives. This action was not completed at the time inspectors re-entered the home to inspect the order on December 7, 2017, as demonstrated by the evidence included in this report.

a) According to an identified CIS, resident #002 consumed an identified amount of medications that belong to another resident. The home assigned one-on-one staff to closely monitor resident #002, as a consult note indicated that resident #002 was likely to engage in some form of self-harm.

b) A review of another identified CIS revealed that PSW #108, who was assigned to closely monitor resident #002 on one-on-one (1:1), reported that the resident gained access and removed sharp items from a specific room which should have remained locked. Further review of the CIS revealed that registered

nursing staff retrieved one of the sharp item before the resident exited the facility with the remaining sharp items in their possession. The CIS also stated that at a later time, resident #002 returned to the home and gained access to the specific room when the door was opened and while staff were removing another resident. While inside that room, the resident had access to sharp items and proceeded to inflict harm to identified areas of their body. The resident was transferred to the acute care hospital for assessment and treatment. On another identified date, sharp items were observed in the specific rooms on multiple floors in the home. And, on that same date, the inspector observed PSW #124 yelling the access code aloud in the hallway.

During an interview, resident #002 stated that they had experienced a condition which they believed could have been relieved by using the sharp items. Resident #002 stated that when they entered the specific room there were multiple sharp items left unattended. The resident told the inspector that they were aware that staff stored the sharp items in that specific room; and that they knew the access code to that room. The resident told the inspector the access code which was confirmed to be correct.

During an interview, PSW #108, who was assigned to provide 1:1 supervision, stated that they observed resident #002 indicating they had a condition; and confirmed that resident #002 told them that during a specific temperature, they experienced the condition; however, the PSW did not share that information with the registered staff. PSW #108 stated that they observed the resident taking sharp items from the specific room and reported the incident to the registered staff as the PSW was not able to approach the resident.

During an interview, RPN #124 stated that they were called by PSW #108 and told that resident #002 had taken sharp items from the specific room. RPN #124 stated that they approached the resident and managed to retrieve one sharp item, and then called the charge nurse RN #125 as resident refused to give up the other sharp items prior to exiting the home.

During an interview RN #125 stated while talking to the RPN and PSW on the unit, the resident returned to the unit and entered the access code to the specific room, went inside and blocked the entrance; then proceeded to cause self-inflict harm to identified areas of the body. RN #125 stated that this incident was a result of neglect as sharp items should not be left anywhere or in any part of the home, and staff should have disposed of sharp items after use. RN #125 also

stated that staff did not want to get close to the resident while providing 1:1 supervision.

In an interview, DOC #101 acknowledged that the staff had not followed the safety procedures put in place to protect resident #002 from self-harm. [s. 5.] (535)

2. On an identified date, the inspector observed that the main dining room doors which separated the resident's main dining room from the non-residential area close to the back elevator, were unlocked and opened with cold air blowing into the dining room directly from outside the building. During the period of time that the door was opened, there was a faint sound of an alarm heard in the vicinity of the doors. The inspector observed that there was a delivery truck at the back exit door of the building unloading supplies for the home; and the back door was propped opened.

During this observation, resident #032 was still sitting in the dining room. The resident's table was directly across from the opened door; therefore they were calling out for someone to close the dining room doors because the air blowing into the room was cold and directly from outside. The inspector requested the assistance of dietary staff #133; and the doors were forced-shut to secure the dining room against the blowing wind.

During an interview, the home's Director of Environmental Services (DES) #112 stated that they were made aware that the magnetic locks for the dining room doors, which led to a non-residential area and access to the back exit, were not closing entirely on the previous day; and that they had noticed that the magnetic locks on that main dining room door were weakened and would sometimes become disengaged whenever the back door was open for delivery. The DES also confirmed that there should have been an alarm sounding whenever the door was left open for an extended period of time; however they were not aware that the alarm was turned down to a minimal volume.

The inspector observed that the DES left the building shortly after the conversation; and they confirmed that they were going out to purchase supplies to repair the dining room doors. In the interim however, the inspector observed, and this information was confirmed by the Director of Dietary Program #131, that there were no signage posted or personnel in place beside the dining room doors to alert staff and residents that the magnet locks were non-functional.

During an interview, DOC #102 was made aware of the incident; and they informed the inspector that the doors should be monitored in the interim until the locks were repaired. The DOC placed a student to monitor the dining room doors until the magnetic locks could be repaired or replaced by the DES. The inspector observed two maintenance workers replacing the magnetic locks on the dining room doors in the afternoon; and the doors were being monitored by the student. [s. 5.] (535)

3. On an identified date, the inspector observed the following sharp items left unattended while performing follow up inspection observations in the home:

In a first identified location, the inspector observed two sharp items were left unattended. During an interview, PSW #121 stated that the sharp items should have been disposed of in the sharp container after use. The PSW removed and disposed of the sharp items in the sharp container.

In a second identified location, the inspector observed sharp items left unattended. During an interview, PSW #119 and registered staff RN #118 informed the inspector that the sharp items should have been disposed of into the sharp container.

In a third location, the inspector observed sharp items left unattended. During an interview, PSW #115 stated the used sharp items should have been disposed in the sharp container, and they disposed of the sharp item in the sharp container. During an interview, PSW #117 and Nurse Manager #116 confirmed that the used sharps should have been disposed of in the sharp container. PSW #117 disposed of the used sharp items in the sharp container.

In a fourth location, the inspector observed sharp items left unattended. During an interview, PSW #113 and registered staff RPN #114 stated that the used sharp items should have been disposed of in the sharp container. PSW # 113 disposed of the sharp items in the sharp container.

During an interview, DOC #101 and #102 stated that the expectation was for direct care staff to dispose of all used sharp items in the sharp container immediately after use.

The severity of this issue was determined to be actual harm/risk to the resident. The scope of this issue was patterned as it was related to more than one resident. The home had ongoing history of non-compliance including a compliance order with this section of the LTCHA during inspection # 2017_324535_0014 issued on October 27, 2017. (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 23, 2018

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2017_630589_0015, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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
(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).

Order / Ordre :

The licensee must be compliant with s. 6 (4) of the LTCHA. Specifically, the licensee shall:

Prepare, submit and implement a compliance plan to ensure that the staff and others involved in the different aspects of care for resident #002, #006, #037 and #038 collaborate with each other, 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.

The compliance plan shall include but is not limited to:

1. Developing and implementing a plan to ensure all staff input related to residents plan of care are discussed and validated as a member of the interdisciplinary team.

2. Developing and implementing a process to ensure collaboration occurs among the interdisciplinary team including but not limited to the BSO staff and other staff that may be leaving the organization.

3. Developing and implementing a plan to ensure physicians' orders, recommendations/suggestions related to resident care are reviewed and implemented as applicable by the nursing and management team on a daily basis.

For the above, as well as for any other elements included in the plan, please include who will be responsible, as well as a timeline for achieving compliance, for each objective/goal listed in the plan.

The plan shall be submitted to the Long Term Care Home Inspector: Veron Ash by Friday, February 9, 2018 via email to: veron.ash@ontario.ca

Grounds / Motifs :

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

On an identified date, the inspector conducted a responsive behavioral record

review related to resident #038 during the follow up inspection.

The licensee has failed to comply with compliance order #001 from inspection #2017_630589_0015 served on October 20, 2017, with a compliance date of November 17, 2017. The licensee was ordered to:

1) Develop and implement a process to ensure collaboration occurs among the interdisciplinary team.
2) The home shall also include scheduled meetings which will allow direct care staff opportunities to collaborate in the development and implementation of the plan of care.
3) Continue to schedule and conduct management and direct care staff meetings that allow for such collaboration with each other in the development and implementation of the plan of care

The home successfully completed items #2 and #3 as ordered; however failed to effectively implement item #1, the process to ensure collaboration amongst the interdisciplinary team as stated in their action plan, at the time inspectors re-entered the home to inspect the order on December 7, 2017; and as demonstrated by the evidence included in this report.

On an identified date, the inspector conducted a responsive behavioral record review related to resident #038 during the follow up inspection.

Record review of the home's minimum data set (MDS) assessment revealed resident #038 had displayed responsive behaviors.

A review of compliance order (CO) #002 issued during Inspection # 2017_630589_0015, dated October 20, 2017, revealed that the home was issued a compliance order related to resident #038's plan of care. The compliance order was due to be complied on November 30, 2017, related to a resident to resident altercation that occurred when resident #038 entered into resident #037's room. Record review and staff interview with DOC #102 revealed that the physician was not made aware of resident #038's responsive behaviors until a later date, after the inspector approached the team during the follow up inspection. A review of the progress notes revealed that on the date the resident was assessed by the physician, the resident was prescribed medication to treat their responsive behaviors; and on another identified date, the resident was referred to the home's BSO team by DOC #102 for assessment

and implementation of interventions related to the resident's responsive behaviors.

On an identified date, the inspector interviewed DOC #101 and #102 related to the previous finding issued by the MOHLTC. DOC #102 confirmed that resident #038's responsive behaviors were not communicated to the physician and the home's BSO team prior to the inspector's re-entry into the home. The DOC further stated that the registered staff should have completed a behavioral referral assessment in point click care which would have triggered contact with the physician and the BSO team; and possibly a referral to the psycho-geriatric outreach program (POP) related to the resident's responsive behaviors. (535)

2. On an identified date, the inspector conducted a responsive behavioral record review related to resident #037 during the follow up inspection.

Record review of the home's minimum data set (MDS) assessment revealed resident #037 had displayed responsive behaviors.

A review of compliance order (CO) #002 issued during Inspection # 2017_630589_0015, dated October 20, 2017, revealed that the home was issued a compliance order related to resident #037's plan of care. Record review of the progress notes revealed that the home's internal behavior support (BSO) team assessed the resident and a progress note was written by the BSO lead on an identified date related to interventions and strategies to put in place to support the resident's responsive behaviors. The home submitted an action plan to the MOH with corrective actions to follow up with and incorporate these BSO interventions within the resident plan of care by November 30, 2017.

The inspector interviewed DOC #101 and #102 regarding resident #037 and the home's action plan related to the previous finding issued by the MOHLTC. The inspector was informed by both DOCs that BSO interventions were not implemented because the team was unaware of the progress notes written by the previous BSO lead who was no longer working in the home; and therefore, the interdisciplinary team was not made aware of the listed BSO interventions; therefore this information was not followed up by the most responsible team members.

During the interview, both DOCs acknowledged that staff and others involved in the different aspects of resident #037 care should have collaborated with each

other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)] (535)

3. On an identified date, the inspector conducted health record reviews related to resident #006 during a follow up inspection.

Record review of the home's minimum data set assessment revealed that resident #006 had an assessment completed which yield information related to mobility, transfer and locomotion abilities of the resident.

Record review of the progress notes revealed that on an identified date, the resident was assessed by physiotherapist # 126 related to safe ambulation. On another identified date, the progress notes revealed that the primary physician documented pertinent information related to the resident's ambulation ability; and documented their medical recommendations related to safety concerns in the electronic documentation system.

Record review of the residents MDS assessment and plan of care revealed that a health condition was not included in the resident's plan of care although the resident was prescribed and administered medication to control the condition.

During separate interviews, primary PSW #106, registered staff RPN #104 and the unit Nurse Manager #103, all confirmed that they were unaware the resident was had the condition; and RPN #104 and Nurse Manager #103 were not aware that the physician had documented the statement related to the safety concerns for the resident because of this condition while ambulating.

During an interview, DOC #102 stated that the physician documented pertinent information in the progress notes which should have been shared with the interdisciplinary team; however the information was not captured in the 24 hour reporting form printed and reviewed daily; and therefore the information was missed and not shared with the interdisciplinary team. The DOC also stated that they thought all physicians documentation in their electronic documentation system were captured consistently on the 24 hours report; and that they would follow up with their head office information technology department to check if physician documentation could be captured in the 24 hours report so that they were not missed in the future. [s. 6. (4) (a)] (535)

4. On an identified date, a critical incident system report (CIS) was submitted to

the MOHLTC regarding an incident of self-harm with a sharp items by resident #002.

Review of DOS monitoring revealed that on an identified date, resident #002 was monitored closely by a 1:1 PSW. Further review of the DOS documentation failed to reveal any change in condition.

Review of resident #002's written plan of care on a specified date, revealed the resident's history and diagnosis.

In an Interview, resident #002 told the inspector that they had experienced an condition prior to the incident of self-harm, and that they had told the 1:1 PSW assigned to them about the condition. The resident further stated that they did not tell registered staff about the condition they had experienced because they believed the registered staff did not have any prescribed medication on file to relieve the condition.

In an interview, PSW #108 stated that they observed resident #002 during the condition, and confirmed that the resident told them about it. PSW #108 confirmed that when they returned to the unit, the resident became engaged in a responsive behaviors toward the registered staff; and they did not inform the registered staff about the resident's condition; and did not document the condition on the DOS documentation.

In an Interview, RPN #124 and RN #125 stated that they were not aware that resident #002 had experienced the condition while they were with the 1:1 PSW off the unit. Both registered staff also stated that they did not ask the 1:1 PSW if an event had occurred with the resident prior to the responsive behavior incident when the resident returned to the unit.

In an Interview, DOC #102 acknowledged that PSW #108, who was assigned to provide 1:1 supervision should have documented the observation and informed the registered staff about the resident's condition when they returned to the unit.

The severity of this issue was determined to be actual harm/risk to the resident. The scope of this issue was patterned as it was related to four residents. The home had ongoing history of non-compliance including a previous compliance

order with this section of the LTCHA during inspection #2017_630589_0015 issued on October 20, 2017. (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 23, 2018

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

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant: 2017_630589_0015, CO #002;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 6 (7). Specifically, the licensee shall ensure that the care is provided to resident #002 as specified in the plan of care.

Grounds / Motifs :

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

The licensee failed to comply with compliance order #002 from inspection #2017_630589_0015 served on October 20, 2017, with a compliance date of November 17, 2017. The licensee was ordered to prepare, submit and implement a plan to ensure that care was provided to residents as specified in the plan of care.

The home failed to effectively implement the plan to ensure that care was provided to residents as specified in the plan of care; and implementation of the plan was not completed at the time inspectors re-entered the home to inspect the order on December 7, 2017, as demonstrated by the evidence included in this report.

On an identified date, inspector #502 observed that resident #002 was to be assisted to the bathroom and post care provided by PSW #122 alone. Record review of the resident plan of care revealed that due to responsive behaviors, the resident required two staff to be present during personal care; and the resident was to be assisted to the bathroom with two staff assistance.

During an interview, PSW #122 stated that they were aware the resident required two staff to be present during personal care; however, the PSW stated that the resident trusted the PSW and did not like having agency staff present; therefore personal care was performed with one staff assistance.

During an interview, DOC #102 stated that personal care should have been performed with two staff present; therefore the PSW did not provide care to the resident as specified in the resident plan of care. (535)

2. On an identified date, a critical incident system report (CIS) was submitted to the ministry of health and long-term care (MOHLTC) about an incident of self-harm with a sharp item by resident #002.

a) Review of the CIS revealed that resident #002 had obtained a sharp item and caused self-inflict harm for which they were transferred to acute care hospital for further assessment and treatment. The CIS further indicated that the home was in the process of obtaining staff to provide one-on-one (1:1) supervision for the resident.

A review of the RAI-MDS assessment was completed related to resident #002.

b) A review of resident #002's written plan of care revealed that resident #002's had a history of self-inflict harm. Further review of the written plan of care revealed a request that a staff of an identified gender should not be involved in the resident's care; however a review of the schedule for 1:1 monitoring staff over an identified period of time revealed that a staff of an identified gender was assigned to closely monitor resident #002 on two listed dates.

Review of resident #002 progress notes revealed that RPN # 124 documented that resident #002 told a PSW assigned to provide 1:1 supervision, that they did not want a staff of an identified gender to provide support or care.

In an interview, the staff #130 confirmed that they had provided 1:1 close supervision for the resident on the two specified dates; and that their responsibility was to prevent the resident from exhibiting responsive behavior that included self-harm.

In an interview, PSW #122 stated that on one of the scheduled date when the resident had an identified gender specific staff for monitoring, resident #002

refused personal care, as the resident believed that the staff assigned would follow and monitor them while personal care was being performed by the direct care staff.

During an interview, resident #002 stated that after ED #100 told them that the identified gender specific staff would be assigned to provide 1:1 close monitoring, the resident requested that they do not have the identified staff provide monitoring.

During an interview, DOC #101 acknowledged that 1:1 monitoring and DOS monitoring were part of responsive behavior management, and that the identified staff should not have been assigned to resident #002. DOC #101 stated that the identified staff was assigned to resident #002 as a last resort, as there was not enough home staff available to provide coverage; and the agency did not have the required staff available to provide monitoring.

During an interview, ED #100 stated that they were advised by the local health integration network (LHIN) to have a one to one staff assign to resident #002 as the resident had a history of self-harm. ED #100 further stated that the agency did not have a required staff available, as a result they did not have a choice but to assign the identified available staff to supervise the the resident. [s. 6. (7)]

The severity of this issue was determined to be actual harm/risk to the resident. The scope of this issue was isolated as it was related to one resident. The home had ongoing history of non-compliance including a previous compliance order with this section of the LTCHA during inspection #2017_630589_0015 issued on October 20, 2017. (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 23, 2018

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this   5th   day of February, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Veron Ash

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