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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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 9, 2018	2018_493652_0011	012811-18	Critical Incident System

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 4E6

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

NATALIE MOLIN (652)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 13, 14, 15, 18, 19, 21,22, and 25, 2018.

The following CIS #2789-000048-18 was inspected; log # 012811-18 related (resident to resident abuse), log # 006200-18 related to (resident to resident abuse).

During the course of the inspection observations of resident to resident interactions were conducted.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSWs), nurse manager (NM), Director of Care (DOC), registered staff, Behaviour Support Lead and Executive Director (ED).

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

In accordance with Reg. 79/10, s.2 (1) for the purpose of the definition of "physical abuse" in subsection
2 (1) of the Act, "physical abuse" means; the use of physical force by a resident that causes physical injury to another resident

A critical incident system report (CIS) was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date in regards to an abuse of a resident by another resident that resulted in harm or risk of harm to the resident.

Resident #002 and resident #003 were roommates. Record review of resident #002's identified healthcare records on an identified date, indicated resident #002 had a fight with resident #003. Resident #003 chased resident #002 out of their room and refused to let resident #002 back into the room. Resident #003 demonstrated an identified behaviour and was approaching resident #002 when RPN #100 had to inform the nurse manager and the decision was made to put resident #002 in another room for the night, the room where resident #001 resided, so that resident #003 could settle. Resident #003 settled in the night when resident #002 was out of sight.

Record review of resident #002's identified healthcare records on an identified date and time indicated when RPN #100 was doing rounds, resident #003 was heard talking inside their room and RPN #100 went and observed resident #003 going over to resident #002, who was lying in their bed at the time, resident #003 tried to remove an object from resident #002 and RPN #100 intervened. Resident #003 then demonstrated an identified behaviour and RPN #100 managed to settle resident #003 a bit. Resident #002 then requested to go to an identified location and PSW #102 brought resident #002's identified assistive device over to resident #002 to take them to the identified location. PSW #102 and resident #002 made their way to the identified location, resident #003 started grabbing on to the identified assistive device of resident #002 and resident #002 refused to let go. It took some talking and distracting in order to get the identified assistive device away from resident #003. Resident #003 pulled the identified assistive device so hard that resident #002 "almost fell", but PSW #102 held up resident #002 and allowed resident #002 to release the identified assistive device before resident #003 yanked it from their reach. Resident #002 walked to the identified location without the assistive device and there it was taken to an identified location to be secured. Resident #002 was assisted out of the room to outside the nursing station to be monitored. Resident #003 then came out of the room and was approaching resident #003 and tried to hit resident #002 when RPN #100 and PSW #101 intervened. Resident #002 was

taken to an identified location to lay down for the remainder of the shift. Resident #003 finally settled down at an identified time and went back to their room. A note was left in the Medical Doctor’s binder by the RN in charge and the MD was also called by the RN in charge for immediate (Stat) and as needed (PRN) medication for resident #003. MD did not return the call at that time. The RPN #100 was directed by RN in Charge to continue to monitor the situation.

Record review of resident #002’s identified healthcare records on an identified date indicated at an identified time, PSW #101 and PSW #102 called RPN #100 reporting resident #002 was found in an identified position, in an identified location. Resident #001 volunteered that resident #002 had a fall, but resident #002 stated the fall was caused by resident #001. Resident #001 stated that they took an identified body part and brushed resident #002. PSW #101 asked resident #001 why did they do that and resident #001 stated " it was not resident #002's room." Resident #002 was assessed by RPN #100 and resident #002 complained of pain in an identified body part. Resident #002 was lifted off the floor via an identified equipment. Resident #002 had an identified impaired skin integrity which was treated and identified protocols initiated and resident #002’s substitute decision maker was notified of the incident. At an identified time the police and ambulance was called and they arrived at an identified time and resident #002 was transferred to hospital.

Record review of resident #002’s identified healthcare records on an identified date indicated the registered staff called an identified hospital at an identified time who reported that resident #002 was admitted with an identified diagnosis.

Record review of resident #002’s identified healthcare records on an identified date and time indicated RPN #100 received a call from the coroner at an identified hospital that resident #002 passed away.

Interview with RPN #100 stated resident #002 and resident #003 had a conflict on an identified date and resident #002 was transferred to an identified location during this time and slept well. RPN #100 also stated resident #002 and resident #003 had a conflict on an identified date and time, whereby resident #003 tried to pull an identified object from resident #002 while they were lying in their identified room. RPN #100 went on to state resident #003 grabbed the assistive device of resident #002 and PSW #101 and PSW #102 had to assist in order for RPN #100 to get the assistive device out of resident #003’s reach. RPN #100 stated resident #002 was placed outside the nursing station until resident #003 settled. Resident #003 came to the nursing station and tried to hit

resident #002. After discussions with the nurse manager resident #002 was transferred to resident #001’s room for the rest of the shift. RPN #100 was informed by PSW #101 and PSW #102 that resident #002 was found lying on an identified position in an identified location and was advised by resident #002 that resident #001 was involved.

Interview with PSW #101 and PSW #102 stated resident #002 stated resident #001 caused them to fall on an identified date. PSWs also stated resident #001 acknowledged they brushed an identified body part on resident #002.

Interview with Executive Director (ED) #109 stated they had been advised by the Detective that the autopsy of resident #002 could not conclude what was the cause of resident #002’s death, but the autopsy did confirm resident #002 had an identified injury.

2 The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A critical incident system report (CIS) was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date and time in regards to an abuse of a resident by another resident that resulted in harm or risk of harm to the resident.

Record review of resident #005’s identified healthcare record on an identified date indicated the personal support worker (PSW) reported at an identified time that resident #005 got into an altercation with resident #004.The PSW indicated, resident #005 was trying to leave their room and touched resident #004’s item and resident #004 did not like their identified item being touched so resident #004 got mad and caused altered skin integrity to #005 on an identified part of the body and they sustained a small injury. The alteration of the skin was treated. "Both residents were separated, no signs and symptoms of discomfort and the Power of Attorney notified (POA)".

Record review of resident #005’s progress notes on an identified date and time indicated the registered staff rechecked resident #005’s identified body part and noticed that resident
#005’s identified body part had sustained injury, was treated and resident #005 voiced no pain at the site during assessment. This note also indicated upon further assessment of the incident by the registered staff resident #005 stated resident #004 hit resident #005 on an identified body part with resident #004's identified assistive device.

Record review of resident #005’s incident note on an identified date indicated DOC #110

spoke to resident #005 about the incident with resident #004 and as per resident #005's roommate resident #004 was engaged in an identified activity when resident #005 was engaging in the same activity, resident #004 went over to resident #005's side and hit resident #005 with their identified assistive device twice on an identified body part, the nurse did the dressing for resident #005 and they stayed out of the room the whole day.

Record review of resident #004's identified healthcare record indicated resident #004 demonstrated responsive behaviours to both residents and staff.

Interview with PSW #111 stated resident #004 hit resident #005 because resident #005 made facial grimaces and touched resident #004's identified item. PSW #111 stated resident #004 did not like their identified item touched.

Interview with DOC #110 stated during their discussion with resident #005 they were advised that resident #004 hit resident #005 and resident #005 told their family member that they were scared because resident #004 always pick on them. Resident #005 was relocated to another room. DOC #110 acknowledged that resident #004 still has access to their identified assistive device and would be looking into different replacement options for resident #004.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A critical incident system report (CIS) was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date and time in regards to an abuse of a resident by another resident that resulted in harm or risk of harm to the resident.

Resident #002 and resident #003 were roommates. Record review of resident #002's progress notes on an identified date, indicated resident #002 had a fight with resident #003. Resident #003 chased resident #002 out of their room and refused to let resident #002 back in the room. Resident #003 demonstrated an identified behaviour and was approaching resident #002 when RPN #100 had to inform the nurse manager and the decision was made to put resident #002 in another room for the night, the room where resident #001 resided so that resident #003 could settle. Resident #003 settled in the night when resident #002 was out of sight.

Record review of resident #002's progress notes on an identified date and time indicated, when RPN #100 was doing rounds, resident #003 was heard talking inside their room and RPN #100 went and observed resident #003 going over to resident #002, who was lying in their bed at the time, resident #003 tried to remove an object of resident #002 and RPN #100 intervened. Resident #003 then demonstrated and identified behaviour and RPN #100 managed to settle resident #003 a bit. Resident #002 then requested to

go to an identified location and PSW #102 brought resident #002's identified assistive device over to resident #002 to take them to an identified location. PSW #102 and resident #002 made their way to the identified location, resident #003 started grabbing on to the identified assistive device of resident #002 and resident #002 refused to let go. It took some talking and distracting in order to get the identified assistive device away from resident #003. Resident #003 pulled the identified assistive device so hard that resident #002 "almost fell", but PSW #102 held up resident #002 and allowed resident #002 to release the identified assistive device before resident #003 yanked it from their reach. Resident #002 walked to the identified location without the assistive device and there it was taken to an identified location to be secured. Resident #002 was assisted out of the room to outside the nursing station to be monitored. Resident #003 then came out of the room and was approaching resident #003 and tried to hit resident #002 when RPN #100 and PSW #101 intervened. Resident #002 was taken to an identified location to lay down for the remainder of the shift. Resident #003 finally settled down at an identified time and went back to his room. A note was left in the Medical Doctor's binder by the RN in charge and the MD was also called by the RN in charge for immediate (Stat) and as needed (PRN) medication for resident #003. MD did not return the call at that time. The RPN #100 was directed by RN in Charge to continue to monitor the situation.

Record review of resident #003's progress notes for an identified period indicated resident #003 demonstrated identified behaviours towards staff, co-residents and visitors. This progress notes also indicated the resident was put on identified monitoring on identified dates, then initiated again. There is no evidence in resident #003's progress notes to indicated when the identified monitoring has been re-evaluated and removed prior to the re-initiating the monitoring on identified dates.

Record review of resident #003's identified monitoring record for an identified period indicated gaps in the monitoring tool for resident #003 during a certain period of time. The monitoring records had no evidence to support staff monitored the resident and documented on the records on two identified dates when resident #002 and resident #003 had the altercation.

Record review of resident #003's identified healthcare record on an identified date, indicated they an identified behavior related to an identified diagnosis. This identified healthcare record also directed staff to do the identfied monitoring hourly.

Record review of the home's policy indicated registered staff will conduct and document an assessment of the resident experiencing an identified behaviour to include completing

an identified assessment based on resident need, including but not limited to identified behavioural tools. This policy also mentioned monitoring and documenting resident's response to new identified medication using identified monitoring and tracking tool.

Interview with PSW #102 stated they were not aware that the identified monitoring tool had to be completed for resident #003 and did not complete this document on an identified date, when the incident occurred between resident #002 and resident #003.

Interviews with RPN #105 and BSO Lead #104 acknowledged there were gaps on the identified monitoring record for resident #002 and resident #003. They both stated the expectation is that the personal support workers monitor resident #003 every 30 minutes and document their observations of the behaviours on this identified tool.

Interview with Nurse Manager #108 stated the expectation is that when a resident has demonstrated behaviours, the registered staff should be responsible for monitoring the resident's behaviours and documenting the behaviours on the identified monitoring tool.

Interview with DOC#110 acknowledged there were gaps on the identified monitoring record for an identified period, and stated the expectation is that the PSWs monitor the resident as per the plan of care every 30 minutes or hourly and document the behaviours on the identified monitoring tool.

Additional Required Actions:

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

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care set out clear directions to staff and others who provide direct care to the resident.

A critical incident system report was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date and time in regards to an abuse of a resident by another resident that resulted in harm or risk of harm to the resident.

Record review of resident #005's progress notes on an identified date indicated the personal support worker (PSW) reported at an identified time that resident #005 got into an altercation with resident #004. The PSW stated resident #005 was trying to leave their room and touched resident #004's item and resident #004 did not like their identified item being touched so resident #004 got mad and caused altered skin integrity to resident #005 on an identified part of the body. Site was cleaned and treated. "Both residents were separated, no signs and symptoms of discomfort and the Power of Attorney notified (POA)".

Record review of resident #005's progress notes on an identified date and time indicated the registered staff rechecked resident #005's identified body part and noticed that resident #005's identified body part had sustained injury, was treated and resident #005

voiced no pain at the site during assessment. This note also indicated upon further assessment of the incident by the registered staff resident #005 stated resident #004 hit resident #005 on an identified body part with resident #004's identified assistive device.

Record review of resident #005's incident note on an identified date indicated DOC #110 spoke to resident #005 about the incident with resident #004 and as per resident #005's roommate resident #004 engaged in an identified activity at that time and when resident #005 engaged in the same activity, resident #004 went over to resident #005's side and hit resident #005 with their identified assistive device twice, on an identified body part, the nurse did the dressing for resident #005 and they stayed out of the room the whole day.

Record review of resident #004's identified healthcare records indicated resident #004 demonstrated identified behaviours to both residents and staff.

Record review of resident #004's physician order indicated a telephone order on an identified date and time for staff to initiate 1 to 1 monitoring on an identified time. Record review of resident #004's identified monitoring record indicated gaps on this record for resident #004.

Record review of resident #004's physician orders on an identified date, indicated an order to start resident #004 on an identified medication. Resident #004's identified healthcare records did not provide a focus, goal or intervention related to this new medication. The BSO Lead indicated in resident #004's identified healthcare records the plan was to start resident #004 on this identified medication for an identified diagnosis and monitor effect, an identified assessment to be done and remove an identified assistive device. Resident #004's identified healthcare records did not reflect that the identified medication had been started and the directive was for staff to monitor and document the effectiveness of the identified medication. There was also no evidence in resident #004's identified healthcare records that the effects of the identified medication had been monitored and documented. The identified assistive device which resident #004 used in the altercation with resident #005 had not been removed. During the resident observations resident #004 was observed walking with the identified assistive device in their room and in the hallways.

Record review of resident #004's identified consultation notes indicated staff to reassess resident #004's identified assessment with an interpreter, during an interview with the BSO Lead #104 they indicated it was completed however during resident #004's records

review there was no evidence to support that this assessment has been completed.

Interview with PSW #111, RPN #105 and BSO Lead #104 indicated the personal support workers are responsible for completing the identified monitoring tool and the registered staff are to review the identified monitoring record at the end of the shift and document the behaviours in an identified healthcare record.

During an interview DOC #110 acknowledged there were gaps in resident #004's identified monitoring record, the new identified medication had not been reflected on resident #004's identified healthcare records, resident #004 continued to use the identified assistive device, and there was no evidence on resident #004's healthcare records that the identified assessment was completed. DOC #110 stated the expectation is that the Personal Support Worker will check resident #004 and document the behaviour on the identified monitoring tool for seven days and the registered staff is to assess the monitoring tool record and document a summary of the behaviour in the resident's identified healthcare records. The expectation is that the BSO lead will make a final analysis of the identified monitoring tool and the demonstrated behaviours.

Record review of the home's identified policy indicated the Registered Staff to complete the identified monitoring tool and monitor and document resident response to new identified medication using the identified monitoring tool and tracking record. This policy does not direct the personal support workers to complete the identified monitoring tool.

Resident #004's identified healthcare records did not clearly state how long to continue 1:1 and who is responsible for evaluating it. This healthcare record also did not include the identified medication as a new intervention and who was responsible for monitoring and documenting the effectiveness of the identified medication.

2. 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.

A critical incident system report was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date and time in regards to an abuse of a resident by another resident that resulted in harm or risk of harm to the resident.

Resident #004 was observed with an identified assistive device in their room and walking along the hallways during the inspection.

Record review of resident #005's progress notes on an identified date indicated the personal support worker (PSW) reported at an identified time that resident #005 got into an altercation with resident #004. The PSW stated resident #005 was trying to leave their room and touched resident #004's item and resident #004 did not like their identified item being touched so resident #004 got mad and caused altered skin integrity to #005 on an identified part of the body. Site was cleaned and treated. "Both residents were separated, no signs and symptoms of discomfort and the Power of Attorney notified (POA)".

Record review of resident #005's progress notes on an identified and time indicated the registered staff rechecked resident #005's identified body part and noticed that resident #005's identified body part had sustained injury, was treated and resident #005 voiced no pain at the site during assessment. This note also indicated upon further assessment of the incident by the registered staff resident #005 stated resident #004 hit resident #005 on an identified body part with resident #004's identified assistive device.

Record review of resident #005's incident note on an identified date indicated DOC #110 spoke to resident #005 about the incident with resident #004 and as per resident #005's roommate resident #004 was engaged in an identified activity and when resident #005 started to engage in the same activity, resident #004 went over to resident #005's side and hit resident #005 with an identified assistive device twice, on an identified body part, the nurse did the dressing for resident #005 and they stayed out of the room the whole day.

The BSO Lead #104 indicated in resident #004's identified healthcare records the plan included removing the identified assistive device.

Interview with BSO Lead #104 confirmed that resident #004's identified assistive device had not been removed.

In an interview with DOC #110 they acknowledged resident #004's identified assistive device had not been removed.

3. The licensee failed to ensure that the provision of the care set out in the plan of care was documented.

A critical incident system report was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date and time in regards to an abuse of a resident by

another resident that resulted in harm or risk of harm to the resident.

Record review of resident #005’s progress notes on an identified date indicated the personal support worker (PSW) reported at an identified time that resident #005 got into an altercation with resident #004. The PSW stated resident #005 was trying to leave their room and touched resident #004’s item and resident #004 did not like their identified item being touched so resident #004 got mad and caused altered skin integrity to resident #005 on an identified part of the body. Site was cleaned and treated. "Both residents were separated, no signs and symptoms of discomfort and the Power of Attorney notified (POA)".

Record review of resident #005’s progress notes on an identified and time indicated the registered staff rechecked resident #005’s identified body part and noticed that resident #005’s identified body part had sustained injury, was treated and resident #005 voiced no pain at the site during assessment. This note also indicated upon further assessment of the incident by the registered staff resident #005 stated resident #004 hit resident #005 on an identified body part with resident #004's identified assistive device.

Record review of resident #005’s incident note on an identified date indicated DOC #110 spoke to resident #005 about the incident with resident #004 and as per resident #005's roommate resident #004 was engaged in an identified activity at that time and when resident #005 started engaging in the same activity, resident #004 went over to resident #005’s side and hit resident #005 with an identified assistive device twice, on an identified body part, the nurse did the dressing for resident #005 and they stayed out of the room the whole day.

Record review of resident #004’s identfied consultation notes indicated staff to reassess resident #004’s identified assessment with an interpreter of an identified culture, during an interview with the BSO Lead #104 they indicated it was completed however during resident #004’s records review there was no evidence to support that this assessment had been completed.

Interview with BSO Lead #104 confirmed that the identified assessment was completed for resident #004 however a record of this assessment was not found.

During an interview DOC #110 acknowledged there was no evidence on resident #004’s healthcare records that the identified assessment was documented.

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

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Issued on this 9th day of October, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NATALIE MOLIN (652)
Inspection No. / No de l'inspection :	2018_493652_0011
Log No. / No de registre :	012811-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 9, 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-4E6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kris Coventry

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)

Pursuant to / Aux termes de :

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

Order / Ordre :

The Licensee must be compliant with s. 19. (1) of the LTCHA.
Specifically the licensee must:

Ensure that residents are protected from physical abuse by other residents.

The home should adopt an interdisciplinary team approach to all residents' internal transfers including temporary room changes to determine residents' suitability through evaluation of but not limited to:

1)The chosen residents' plan of care, documentation of behaviours, identified behavioural triggers and level of physical functioning to reduce the risk of resident to resident physical altercations.

2) To assess and provide residents with safe alternative tools for Activities of Daily Living (ADLs).

3) The decision should be documented to include the rationale for the decision, staff involved in the decision and the date.

4) Review the staffing compliment and/or assignments on the night shift to determine how the staff will manage residents who demonstrate responsive behaviours on the second floor.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A critical incident system report (CIS) was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date and time in regards to an abuse of a resident by another resident that resulted in harm or risk of harm to the resident.

Record review of resident #005's identified healthcare record on an identified date indicated the personal support worker (PSW) reported at an identified time that resident #005 got into an altercation with resident #004.The PSW indicated, resident #005 was trying to leave their room and touched resident #004's item and resident #004 did not like their identified item being touched so resident #004 got mad and caused altered skin integrity to #005 on an identified part of the body and they sustained a small injury. The alteration of the skin was treated. "Both residents were separated, no signs and symptoms of discomfort and the Power of Attorney notified (POA)".

Record review of resident #005's progress notes on an identified date and time indicated the registered staff rechecked resident #005's identified body part and noticed that resident
#005's identified body part had sustained injury, was treated and resident #005 voiced no pain at the site during assessment. This note also indicated upon further assessment of the incident by the registered staff resident #005 stated resident #004 hit resident #005 on an identified body part with resident #004's identified assistive device.

Record review of resident #005's incident note on an identified date indicated DOC #110 spoke to resident #005 about the incident with resident #004 and as per resident #005's roommate resident #004 was engaged in an identified activity when resident #005 was engaging in the same activity, resident #004 went over to resident #005's side and hit resident #005 with their identified assistive device twice on an identified body part, the nurse did the dressing for resident #005 and they stayed out of the room the whole day.

Record review of resident #004's identified healthcare record indicated resident #004 demonstrated responsive behaviours to both residents and staff.

Interview with PSW #111 stated resident #004 hit resident #005 because resident #005 made facial grimaces and touched resident #004's identified item. PSW #111 stated resident #004 did not like their identified item touched.

Interview with DOC #110 stated during their discussion with resident #005 they were advised that resident #004 hit resident #005 and resident #005 told their family member that they were scared because resident #004 always pick on them. Resident #005 was relocated to another room. DOC #110 acknowledged that resident #004 still has access to their identified assistive device and would be looking into different replacement options for resident #004.

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2. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

In accordance with Reg. 79/10, s.2 (1) for the purpose of the definition of "physical abuse" in subsection
2 (1) of the Act, "physical abuse" means; the use of physical force by a resident that causes physical injury to another resident

A critical incident system report (CIS) was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date in regards to an abuse of a resident by another resident that resulted in harm or risk of harm to the resident.

Resident #002 and resident #003 were roommates. Record review of resident #002's identified healthcare records on an identified date, indicated resident #002 had a fight with resident #003. Resident #003 chased resident #002 out of their room and refused to let resident #002 back into the room. Resident #003 demonstrated an identified behaviour and was approaching resident #002 when RPN #100 had to inform the nurse manager and the decision was made to put resident #002 in another room for the night, the room where resident #001 resided, so that resident #003 could settle. Resident #003 settled in the night when resident #002 was out of sight.

Record review of resident #002's identified healthcare records on an identified date and time indicated when RPN #100 was doing rounds, resident #003 was heard talking inside their room and RPN #100 went and observed resident #003 going over to resident #002, who was lying in their bed at the time, resident

#003 tried to remove an object from resident #002 and RPN #100 intervened. Resident #003 then demonstrated an identified behaviour and RPN #100 managed to settle resident #003 a bit. Resident #002 then requested to go to an identified location and PSW #102 brought resident #002's identified assistive device over to resident #002 to take them to the identified location. PSW #102 and resident #002 made their way to the identified location, resident #003 started grabbing on to the identified assistive device of resident #002 and resident #002 refused to let go. It took some talking and distracting in order to get the identified assistive device away from resident #003. Resident #003 pulled the identified assistive device so hard that resident #002 "almost fell", but PSW #102 held up resident #002 and allowed resident #002 to release the identified assistive device before resident #003 yanked it from their reach. Resident #002 walked to the identified location without the assistive device and there it was taken to an identified location to be secured. Resident #002 was assisted out of the room to outside the nursing station to be monitored. Resident #003 then came out of the room and was approaching resident #003 and tried to hit resident #002 when RPN #100 and PSW #101 intervened. Resident #002 was taken to an identified location to lay down for the remainder of the shift. Resident #003 finally settled down at an identified time and went back to their room. A note was left in the Medical Doctor's binder by the RN in charge and the MD was also called by the RN in charge for immediate (Stat) and as needed (PRN) medication for resident #003. MD did not return the call at that time. The RPN #100 was directed by RN in Charge to continue to monitor the situation.

Record review of resident #002's identified healthcare records on an identified date indicated at an identified time, PSW #101 and PSW #102 called RPN #100 reporting resident #002 was found in an identified position, in an identified location. Resident #001 volunteered that resident #002 had a fall, but resident #002 stated the fall was caused by resident #001. Resident #001 stated that they took an identified body part and brushed resident #002. PSW #101 asked resident #001 why did they do that and resident #001 stated " it was not resident #002's room." Resident #002 was assessed by RPN #100 and resident #002 complained of pain in an identified body part. Resident #002 was lifted off the floor via an identified equipment. Resident #002 had an identified impaired skin integrity which was treated and identified protocols initiated and resident #002's substitute decision maker was notified of the incident. At an identified time the police and ambulance was called and they arrived at an identified time and resident #002 was transferred to hospital.

Record review of resident #002's identified healthcare records on an identified date indicated the registered staff called an identified hospital at an identified time who reported that resident #002 was admitted with an identified diagnosis.

Record review of resident #002's identified healthcare records on an identified date and time indicated RPN #100 received a call from the coroner at an identified hospital that resident #002 passed away.

Interview with RPN #100 stated resident #002 and resident #003 had a conflict on an identified date and resident #002 was transferred to an identified location during this time and slept well. RPN #100 also stated resident #002 and resident #003 had a conflict on an identified date and time, whereby resident #003 tried to pull an identified object from resident #002 while they were lying in their identified room. RPN #100 went on to state resident #003 grabbed the assistive device of resident #002 and PSW #101 and PSW #102 had to assist in order for RPN #100 to get the assistive device out of resident #003's reach. RPN #100 stated resident #002 was placed outside the nursing station until resident #003 settled. Resident #003 came to the nursing station and tried to hit resident #002. After discussions with the nurse manager resident #002 was transferred to resident #001's room for the rest of the shift. RPN #100 was informed by PSW #101 and PSW #102 that resident #002 was found lying on an identified position in an identified location and was advised by resident #002 that resident #001 was involved.

Interview with PSW #101 and PSW #102 stated resident #002 stated resident #001 caused them to fall on an identified date. PSWs also stated resident #001 acknowledged they brushed an identified body part on resident #002.

Interview with Executive Director (ED) #109 stated they had been advised by the Detective that the autopsy of resident #002 could not conclude what was the cause of resident #002's death, but the autopsy did confirm resident #002 had an identified injury.

The severity of this issue was determined to be a level 3 as resident #002 and resident #005 experienced actual harm. The scope of the issue was a level 1 as it relates to both residents. The home had a level 4 compliance history as they had related ongoing non-compliance with this section of the LTCHA that included: voluntary plan of correction (VPC) issued April 25, 2016 (2016_226192_0014); compliance order (CO) #009 issued December 23, 2016,

with a compliance due date May 24, 20170020 2016_353589_0016); voluntary plan of correction (VPC) issued May 24, 2017 (2017_644507_0003);compliance order (CO) #001 issued October 20, 2017, with a compliance due date December 21, 2017 (2017_632501_0014).

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This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 10, 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 9th day of August, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector /
Nom de l'inspecteur : Natalie Molin

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